Dixon Girls Softball

Medical Release

Player: ______________________________ Date of Birth: ______________________Gender: M or F
Parent(s)/Legal Guardian Name: ______________________ Relationship:_____________________________
Parent(s)/Legal Guardian Name: ______________________ Relationship:_____________________________
Player's Address: ______________________ City: _______________ State/Country: _____ Zip: ____________
Home Phone: _______________ Work Phone: __________________ Mobile Phone: ____________________

PARENT OR LEGAL GUARDIAN AUTHORIZATION

In case of emergency, if family physician cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel (i.e. EMT, First Responder, E.R. Physician).

Family Physician: ________________________________ Phone: ___________________________________
Address: _________________________________ City: __________________ State/Country: ______________
Hospital Preference: ____
Parent Insurance Co.:______________________ Policy No.:___________________ Group ID#: ____________
League Insurance Co.: _____________________ Policy No.: _____________ League/Group ID#: ___________
If Parent(s)/Legal Guardian cannot be reached in case of emergency, contact:

____
Name Phone Relationship to player

____
Name Phone Relationship to player

Please list any allergies/medical problems, including those requiring maintenance medication (i.e. Diabetic, Asthma, Seizure disorder).

Medical Diagnosis	Medication	Dosage	Frequency of Dosage

Date of the last Tetanus Toxoid Booster: ____________________________

The purpose of the above information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.

Mr./Mrs./Ms. ____
Authorized Parent/Legal Guardian Signature

FOR LEAGUE USE ONLY:
League Name: _____________________________________ League ID:__________________________
Division: ___________________ Team: ____________________ Date: _______________________