



MEDICAL/DENTAL RELEASE FORM

Player Name: _____

Parents Name: _____

Birth Date: _____

Address: _____

Phones: _____

Allergic to any Medications? _____

Emergency Notifications:

Name/Phone: _____

Name/Phone: _____

Name/Phone: _____

Doctor

Doctor's Name: _____ Phone: _____

Doctor's Address: _____

Dentist

Dentist's Name: _____ Phone: _____

Dentist's Address: _____

Insurance

Insurance Carrier: _____

Insured Person: _____

Policy Number: _____

CONSENT FOR TREATMENT

In case of an emergency, I, _____, parent or legal guardian of _____ Association to take _____ for medical and/or dental treatment if deemed necessary.

By: _____

Date: _____