Macon County Youth Baseball

MEDICAL RELEASE

NOTE: To be carried by any Regular season or Tournament Team Manager Together with Team Roster

Player: _____ Date of Birth: _____Gender: (M/F: _____

Parent (s) /Guardian Name: _____ Relationship: _____

Parent (s) /Guardian Name: _____ Relationship: _____

Player's Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Parent or legal guardian authorization: Email: _____

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: _____

Hospital Preference: _____

Parent Insurance Co. _____ Policy #: _____ Group #: _____

League Insurance Co.: _____ Policy #: _____ Group #: _____

If Parent(s)/legal guardian cannot be reached in case of emergency contact:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

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 last Tetanus Toxoid Booster: _____

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

Authorized Parent/Guardian Signature: _____ Date:_____

For League Use Only:

Division: _____ Team: _____ Date: _____

Manager/Head Coach: _____ Phone: _____