SCC S.W.A.T. Fastpitch

Medical Release Form

Player's Name: _____ _____ **Birth Date**: ___/___/___
First Last M D Y

Does your child suffer from any of the following conditions? (Please circle Yes or No for each one)

Yes No Asthma?
Yes No Heart condition?
Yes No Seizures?
Yes No Recent bone/ joint/ muscle/ tendon injury? If yes, describe_____
Yes No Diabetes? If yes, on Insulin? Yes No

List any other medical condition we should know about. _____
_____

Does your child use any of the following medications?
Yes No Epipen?
Yes No Anakit?
Yes No Inhaler for Asthma? If yes, which one? _____
What prescription medication does he/she regularly take? _____

Doctor's Name: _____ Doctor's Phone: _____

Dentist's Name: _____ Dentist's Phone: _____

Hospital Preference: _____

Emergency Contact (other than parent): _____
(Name) (Phone) (Relationship to Player)

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)

Mr. /Mrs. /Ms. _____
Printed Name

Mr. /Mrs. /Ms. _____ Date: _____
Authorized Parent/Guardian Signature