

PLYMOUTH YOUTH BASEBALL

MEDICAL RELEASE FORM

As the parent/legal guardian of _____ (player's name), I request that in my absence the above named player be admitted to any hospital or medical facility for diagnosis and treatment. I request an authorized physician, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technician or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above named player. I have not been given guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named player.

Player's Date of Birth _____ Date of Last Tetanus _____

Known Allergies _____

Known Medical Problems _____

Health Restrictions _____

Family Physician _____ Phone _____

Insurance Carrier _____ Policy Number _____

Signature of Parent/Legal Guardian

Date