CHRISTIAN CENTRAL ACADEMY

Sports Medical Release Form

As the parent/legal guardian of _____, I request in my absence the above named player be admitted to any hospital or medical facility for diagnosis treatment. I request and authorize *physicians, dentists,* and *staff*, **duly licensed** as *Doctors of Medicine* or *Doctors of Dentistry* or other licensed *technicians* or *nurses*, to perform any *diagnostic procedures, treatment procedures, operative procedures* and *x-ray treatment* for the above minor. I have not been given a guarantee as to the results of the examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above player.

Signature of parent/guardian: _____ ***Date***: _____

Address: _____
(street) (city) (state) (zip code)

Home Phone: _____ Work Phone: _____ Cell/Pager: _____

EMERGENCY CONTACT (*if parent is unavailable*): _____

Address: _____
(street) (city) (state) (zip code)

Home Phone: _____ Work Phone: _____ Cell/Pager: _____

PERSON RESPONSIBLE FOR CHARGES *(if different from parent/guardian):* _____

Address: _____
(street) (city) (state) (zip code)

Home Phone: _____ Work Phone: _____ Cell/Pager: _____

Date of Player's Birth: _____/_____/_____ Date of last Tetanus Booster: _____/_____/_____

Known allergies of this player (*including any allergies to medicine*): _____

_____

Any other medical problems which should be noted: _____

_____

Current Medications: _____

Family Physician: _____ **Phone**: _____

INSURANCE CARRIER: _____ **I.D.#** _____

Address: _____
(street) (city) (state) (zip code)

Phone: _____