



*Medical Release Form*

**Player Name** \_\_\_\_\_  
**Date of Birth** \_\_\_\_\_  
**Address** \_\_\_\_\_  
**City** \_\_\_\_\_ **ZIP** \_\_\_\_\_  
**Home Phone** \_\_\_\_\_ **Cell Phone** \_\_\_\_\_

**Parent or Guardian Authorization**

In case of emergency **I/We** the Parents or Guardian of the above named player do hereby authorize my child to be treated by Certified Emergency Personnel (i.e. EMT, First Response, ER Physician). **I/We** the Parents or Guardian of the above named player do hereby consent to medical, surgical, and hospital care, treatment and procedures to be performed for my child listed above by a licensed physician or hospital when deemed immediately necessary or advised by the physician to safeguard my child's health. If we cannot be contacted **I/We** waive my/our right of informed consent to such treatment.

**Signature of Parent or Guardian** \_\_\_\_\_

Insurance Company Name \_\_\_\_\_  
Insurance # or Group # \_\_\_\_\_ Member # \_\_\_\_\_  
Allergies \_\_\_\_\_  
Regular Medication \_\_\_\_\_  
Chronic Illnesses \_\_\_\_\_

**Certificate for Acknowledgement in an Individual Capacity**

State of Washington, County of \_\_\_\_\_ ) ss

**I certify that I know or have satisfactory evidence that \_\_\_\_\_  
Is the person who appeared before, and said person acknowledged that (he/she) signed this instrument and acknowledged it to be (he/she) free and voluntary act for the uses and purpose mentioned in the instrument.**

**Dated** \_\_\_\_\_

(Seal)

\_\_\_\_\_  
**Notary Public in and for the State of Washington**

\_\_\_\_\_  
**Printed Name**

**Residing at** \_\_\_\_\_

**My appointment expires:** \_\_\_\_\_