

**MEDICAL RELEASE / CONSENT FOR TREATMENT**

In my/our absence, I/We authorize medical, surgical and dental treatment, both emergency and non-emergency, considered necessary and proper for the diagnosis and treatment of my/our child listed previously. I/We further authorize the manager or coach, assistant managers or coaches to cause my/our child be transported to Crittenton Hospital Medical Center or to the nearest medical facility for treatment of any illness/injury as above.

Division [ ] Team [ ] Player Name [ ]

**Medical Information**

Family Physician [ ] Telephone [ ] Hospital Preference [ ]

**Please list any allergies, medical problems or physical limitations**

Medical Condition [ ] Medication [ ]

I/WE HAVE READ THE ABOVE WAIVER AND CONSENT, AND UNDERSTAND THEM, AND BY SIGNING BELOW, I/WE AGREE TO THEM.

Parent/Guardian Name \_\_\_\_\_

Parent/ Guardian Signature \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Little League does not limit participation in its activities on the basis of disability, race, color, creed, national origin, gender, sexual preference or religious preference.

**Manager's Copy**

**FILL OUT TOP AND BOTTOM, DO NOT DETACH – RETURN TO MANAGER PRIOR TO FIRST PRACTICE**

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