Plaza Little League
VOLUNTEER MEDICAL RELEASE

NOTE: To be kept with the volunteer application maintained by the League President.

Volunteer: _____ Date of Birth: _____ Gender (M/F): _____

VOLUNTEER AUTHORIZATION:

In case of emergency, if family physician cannot be reached, I hereby authorize to be treated by Certified Emergency Personnel. (i.e. EMT, First Responder, E.R. Physician)

Family Physician: _____ Phone: _____

Address: _____ City: _____ State: _____

Hospital Preference: _____

Health Insurance Co: _____ Policy No.: _____Group ID#: _____

League Insurance Co: _____ Policy No.: _____League/Group ID#: _____

In case of emergency, contact:

_____

Name Phone Relationship to Volunteer

_____

Name Phone Relationship to Volunteer

Please list any allergies/medical problems, including those requiring maintenance medication. (i.e. Diabetic, Asthma, Seizure Disorder)

Medical Diagnosis	Medication	Dosage	Frequency of Dosage

Date of last Tetanus Toxoid Booster: _____

The purpose of the above listed information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.

Mr./Mrs./Ms. _____

Volunteer Signature Date

FOR LEAGUE USE ONLY:

League Name:_____ League ID:_____

Division:_____Team:_____ Date:_____

WARNING: PROTECTIVE EQUIPMENT CANNOT PREVENT ALL INJURIES A PLAYER MIGHT RECEIVE WHILE PARTICIPATING IN BASEBALL/SOFTBALL.

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.