

**Nanticoke Rookie League Inc**  
**MEDICAL RELEASE**

Player: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender (M / F): \_\_\_\_\_

Parent(s)/Legal Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Parent (s)/Legal Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Player's Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Country: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

**PARENT OR LEGAL GUARDIAN AUTHORIZATION:** \_\_\_\_\_ Email: \_\_\_\_\_

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

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Country: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

Parent Insurance Co.: Policy No.: \_\_\_\_\_ Group ID#: \_\_\_\_\_

**Additional Contacts if Parent or Legal Guardian cannot be reached in case of emergency, contact:**

\_\_\_\_\_

Name	Phone	Relationship to Player
------	-------	------------------------

\_\_\_\_\_

Name	Phone	Relationship to Player
------	-------	------------------------

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-mentioned information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.

Mr./Mrs. I.Ms. \_\_\_\_\_

Authorized Parent/Legal Guardian Signature

Date: \_\_\_\_\_