



# Land Park Pacific Little League 2014 Fall Ball



## MEDICAL RELEASE FORM

Please Print Clearly

Player's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Zip: 958 \_\_\_\_\_

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (circle) Male Female

Player Registering For: (circle) Clinic League play Both (Age as of April 30, 2014) \_\_\_\_\_

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

Parent/Guardian 1's Work Phone: \_\_\_\_\_ Parent/Guardian 2's Work Phone: \_\_\_\_\_

Parent/Guardian 1's Home Phone: \_\_\_\_\_ Parent/Guardian 2's Home Phone: \_\_\_\_\_

Parent/Guardian 1's Pager/cell phone: \_\_\_\_\_ Parent/Guardian 2's Pager/cell Phone: \_\_\_\_\_

Parent/Guardian 1's E-mail address: \_\_\_\_\_ Parent/Guardian 2's E-mail address: \_\_\_\_\_

In case of emergency and neither parent can be reached please contact: Name \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

In the event of an accident or other emergency, and when a parent or/a guardian is not available, I/We hereby authorize the manager, coach, or other league personnel to make such arrangements that he/she considers necessary for my/our child to receive medical and hospital care, including necessary transportation.

In case of emergency, if family physician 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: \_\_\_\_\_ Hospital Preference: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Insurance/Medical Record Number: \_\_\_\_\_

The purpose of the below information is to ensure that medical personnel have details of any medical problem that may interfere with or alter treatment. List any allergies/medical problems or diagnosis including those requiring maintenance medications (i.e. Diabetic, Asthma, Seizure Disorder) with information on medication, dosage, frequency of dosage the player may have:

\_\_\_\_\_

Significant past Illness or Injury: \_\_\_\_\_

Date of last Tetanus Toxoid Booster if known: \_\_\_\_\_

### WARNING

*Protective equipment cannot prevent all injuries a player might receive while participating in Little League.*

*By signing below, I/we affirm that I/we understand the risks associated with participation in Little League. I/We understand the authorization I/we have executed, that the information provided on this form is accurate, and that I/we authorize the carrier of this form to seek medical attention in my/our absence for my/our above listed child.*

\_\_\_\_\_  
Authorized Parent or Guardian Signature

\_\_\_\_\_  
Authorized Parent or Guardian Signature

**Medical Release Authorization Form is to be carried by the Fall Ball Manager.**

***(Medical Release form shall be returned to the League and/or destroyed due to the confidentiality of the information.)***