# WEST HOLMES YOUTH BASEBALL MEDICAL RELEASE

Player:_____ Date of Birth:_____ Gender Male or Female

Parent/Guardian Name:_____ Relationship_____

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Players Address:_____ City_____ State_____ Zip_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

**PARENT OR GAURDIAN AUTHORIZATION:** In case of emergency, if family physician cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel (EMT, First Responder, Physician)

Family Physician:_____ Phone:_____

Address:_____ City:_____ State:_____

Hospital Preference:_____

If parent/guardian cannot be reached in case of an emergency, please contact:

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

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

| Medical Diagnosis | Medication | Dosage | Frequency of Dosage |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Date of last Tetanus Booster:_____

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

_____

Authorized Parent/Guardian Signature Date