

MEDICAL RELEASE

(PLEASE PRINT)

Youth's Name

Street Address

Birthdate

City

ZIP

Parent (Name & Phone)

Home Phone

Emergency Contact (Name & Phone)

Cell Phone

I (we) understand that, in the event medical treatment is required, every effort will be made to contact me. However, if I cannot be reached, I give my permission to the staff or sponsor to secure the services of a licensed physician to provide the care necessary, including anesthesia, for my child's well-being.

Signature of Parent or Guardian

Date

Please list any medical allergies, medications being taken, medical problems or other pertinent information: _____

Health Insurance Company _____

Policy # _____

Phone _____