MEDICAL RELEASE FORM

I,_____ (Parent/Guardian's Name) hereby give permission for any and all medical attention to be administered to my child _____ (Child's Name) In the event of accident, injury, sickness, etc., under the direction of the person(s) listed below, until such time as I may be contacted. I also assume the responsibility for the payment of any such treatment. This release is effective for the period of one year from the date given below.

Address:_____

City: _____, FL ZipCode:_____

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Insurance Company:_____

Policy Number: _____ Physician Name: _____

Parent's Email Address:_____@_____

Physician's Address:_____

Physician's Phone:_____

Known Allergies:_____

In case I cannot be reached, any of the following persons is designated to act on my behalf.

* Coach Name: _____
* Assistant Coach: _____
* Team Manager: _____
* A league representative where my child is playing.
* Any tournament representative where my child is participating in a tournament

SIGNATURE (PARENT/GUARDIAN) _____ DATE: _____/_____/_____

Subscribed and sworn before me, This _____ day of _____ , 20____

Notary Signature _____