Mid Valley Sports Leagues @ Valley Beth Shalom

MEDICAL RELEASE

NOTE: To be carried by any Season, Clinic or Tournament Team Manager together with team roster.

Player: _____ **Date of Birth:** _____ **Gender:**_____
Player's Address:_____ **City:**_____ **State:**_____ **Zip:**_____

In case of emergency, contact: _____Phone:_____
Hospital Preference: _____
Insurance Co:_____ Policy No.:_____Group ID#:_____

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 Booster: _____
The purpose of the above listed information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.

IF MINOR PLAYER:
Parent (s)/Guardian Name:_____
Relationship:_____
Home Phone:_____ Work Phone:_____ Cell: _____
Parent (s)/Guardian Name:_____
Relationship:_____
Home Phone:_____ Work Phone:_____ Cell: _____

If parent(s)/legal guardian cannot be reached in case of emergency, contact:

Name:_____ Phone:_____Relationship to Player:_____
Family Physician: _____ Phone: _____
Address: _____
City:_____ State:_____

PARENT OR LEGAL GUARDIAN AUTHORIZATION:
☐ 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)

SIGNATURE OF ADULT OR PARENT/GUARDIAN
Date: _____

_____
Signature

EMAIL THIS FORM TO MVSL@VBS.ORG