ALVINSTON MINOR BALL MEDICAL RELEASE FORM

NOTE: This document is to be carried at all times by any regular season or tournament coach.

Player's Full Name: _____

Gender: M / F **Date of Birth (month/day/year):** _____

Parent/Guardian Name(s): _____

Phone: (Home): (____)_____ **(Cell):** (____)_____

Family Physician: _____ **Phone (if known):** (____)_____

Please list any allergies/medical problems, including those requiring medication (i.e. diabetic, asthma, seizure disorder, etc.).

Medical Diagnosis/Allergy:_____

Medication & Dosage:_____

Other relevant medical information: _____

_____

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

Name: _____ Phone: (____)_____
Relationship to Player:_____

Name: _____ Phone: (____)_____
Relationship to Player:_____

PARENT/GUARDIAN AUTHORIZATION

WARNING: PROTECTIVE EQUIPMENT CANNOT PREVENT ALL INJURIES A PLAYER MIGHT RECEIVE WHILE PARTICIPATING IN BASEBALL/SOFTBALL.

I give permission for my child to participate in all Alvinston Minor Ball Association events and activities including, but not limited to, practices, games and tournaments. I hereby state that he/she is physically able to do the activities therein. I will not hold Alvinston Minor Ball Association, Four Counties Minor Softball, Central Lambton Fastball League, Western Counties Baseball Association, Municipality of Brooke-Alvinston or any other employee or volunteer thereof liable for any injuries that may result from my child's participation in these activities. I understand that the above information is collected to ensure that coaches and medical personnel have current medical information and details of any medical problem which may interfere with or alter the treatment of my child. In case of emergency, I hereby authorize my child to be treated by Certified Emergency Personnel (i.e. EMT, First Responder, E.R. Physician). I give permission for emergency medical treatment in the event I cannot be reached.

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**