

Little League Baseball and Softball M E D I C A L R E L E A S E



NOTE: To be carried by any Regular Season or Tournament Team Manager together with team roster or International Tournament affidavit.

Player:	Date of E	Birth:	Gend	er (M/F):		
Parent (s)/Guardian Name:		Relationship:				
Parent (s)/Guardian Name:			Relationship:			
Player's Address:	Cit	y:	State,	/Country:	Zip:	
Home Phone:		Mobile Ph	Mobile Phone:			
PARENT OR LEGAL GUARDIAN	AUTHORIZATION:		Email:			
In case of emergency, if family pl Emergency Personnel. (i.e. EMT,		reby aut	horize my child to	be treated by C	Certified	
Family Physician:		Phone:				
Address:	Cit	y:	State/Country:			
Hospital Preference:						
Parent Insurance Co:	Policy No.:	Policy No.:		Group ID#:		
League Insurance Co:	Policy No.:_		League/Group ID#:			
If parent(s)/legal guardian canno	ot be reached in case of emerge	ency, con	tact:			
Name	Ph	Phone Relationship to Player		layer		
Name	Ph	Phone Relationship to Player				
	roblems, including those requiring n	naintenar				
Medical Diagnosis	Medication		Dosage	Frequen	cy of Dosage	
Date of last Tetanus Toxoid Boost	er:					
The purpose of the above listed information	on is to ensure that medical personnel hav	e details of	f any medical problem w	hich may interfere	with or alter treatment	
Mr./Mrs./MsAuthorized Par	rent/Guardian Signature				Date:	
FOR LEAGUE USE ONLY:						
League Name:		League ID:				
Division:	Team:			Date:		