

H0LTON BASEBALL MEDICAL RELEASE

Player's Name: _____

D. O. B.: ____/____/____ Age: _____ Grade: _____ Male / Female

Parent's Name(s): _____

Home Phone: _____ Work Phone: _____

Parent or Guardian Authorization

In case of an emergency, if I, or the family physician, cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel (i.e. EMT, First Responder, ER Physician).

Family Physician: _____ Phone: _____

Address: _____ City: _____

Hospital Preference: _____

Emergency Contacts, other than parents.

Name: _____ Relationship: _____

Home: _____ Cell: _____ Work: _____

Name: _____ Relationship: _____

Home: _____ Cell: _____ Work: _____

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

Medical Diagnosis	Medication	Dosage	Frequency of Dosage
-------------------	------------	--------	---------------------

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

Mr./Mrs. _____ Date: _____

Authorized Parent/Guardian's Signature

Warning: Protective equipment cannot prevent all injuries a player might receive while participating in baseball.

Little League Baseball does not limit participation in its activities on the basis of disability, race, color, creed, national origin, gender or religious preference.