BLOOMFIELD BABE RUTH LEAGUE

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Medical Release Form

Note: To be carried by any regular Season or Tournament Team Manager
together with team roster or eligibility affidavit.

Player's Name: ________________________ **Date of Birth:** ____________________

Family Physician: ______________________ **Office Number:** ____________________

Hospital Preference: ____

Insurance Carrier: ____

I.D. Number (NOT GROUP #): _____________________________________

In Case of Emergency Contact:

(Other than parents)

Name: ____

Home Phone #: ______________________ **Cell Phone #:** ____________________

Relationship to Player: ____

Please list any allergies/medical problems, including that requiring maintenance medication. (i.e. Diabetic, Asthma, Seizure Disorder, etc.) Use back of form if more space required.

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 problem which may interfere with or alter treatment.

Date of last Tetanus Toxoid Booster: ____

In the event reasonable attempts to contact the parent or guardian have been unsuccessful, I hereby give my cosent for (1) the administration of any treatment deemed necessary by preferred Doctor or (2) preferred Dentists or in the event designated Doctor or Dentist is not available, by another licensed Doctor or Dentist; and (3) the transfer of the child to preferred hostpital or any hospital reasonably accessible. Note: This authorization does not cover major surgery unless the medical options of two other licensed physicians or dentist, concurring in necessity for such surgery are obtained BEFORE the surgery IS PERFORMED.

Authorized Parent/Guardian:

Name: ____

Signature: ________________________ **Date:** ____________________