TOWN OF GILA BEND
RECREATION – MEDICAL RELEASE FORM

LEAGUE: Youth Soccer

PLAYER NAME:	**DATE OF BIRTH:**

Parent/Guardian Name: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Player Address: _____ City: _____ State: _____ Zip: _____

FAMILY PHYSICIAN INFORMATION

Physician Name: _____

Phone: _____

Hospital preference: _____

Address: _____

City/State/Zip: _____

EMERGENCY CONTACT INFORMATION
If parent or legal guardian cannot be reached

#1	**#2**
Name: _____	Name: _____
Cell Phone: _____	Cell Phone: _____
Home Phone: _____	Home Phone: _____
Work Phone: _____	Work Phone: _____
Relationship to player: _____	Relationship to player: _____

List any allergies/medical problems, including those requiring maintenance medication (i.e. Diabetic, Asthma, Seizure Disorder). The purpose of the information listed below is to ensure medical personnel have details of any medical concern that may interfere with or alter treatment. Use an additional sheet of paper if necessary, and attach to Medical Release Form.

Medical Diagnosis	Medication	Dosage	Frequency of Dosage

MEDICAL COVERAGE INFORMATION

Insurance Carrier: _____

Policy ID#: _____ Group ID#: _____

PARENT/LEGAL GUARDIAN AUTHORIZATION

Parent or 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 Respondent, E.R. Physician).

Parent signature _____ Date: _____