

**TOWN OF GILA BEND
RECREATION – MEDICAL RELEASE FORM**

LEAGUE/SPORT NAME: _____

PLAYER NAME: _____

DATE OF BIRTH: _____

Parent/Guardian Name: _____

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

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

FAMILY PHYSICIAN INFORMATION

Physician Name: _____

Address: _____

Phone: _____

City/State/Zip: _____

Hospital preference: _____

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: _____