



## SYSL MEDICAL RELEASE FORM

I, \_\_\_\_\_ (Parent/Guardian's Name) hereby give permission for any and all medical attention to be administered to my child \_\_\_\_\_ (Child's Name) in the event of accident, injury, sickness, etc., under the direction of the person(s) listed below, until such time as I may be contacted. I also assume the responsibility for the payment of any such treatment. This release is effective for the period of one year from the date given below.

ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ Work Phone: \_\_\_\_\_

INSURANCE COMP: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_

In case I cannot be reached, any of the following persons is designated to act on my behalf.

\* COACH: \_\_\_\_\_

\* ASST.COACH: \_\_\_\_\_

\* MANAGER: \_\_\_\_\_

\* A league representative where my child is playing.

\* Any tournament representative where my child is participating in a tournament

PHYSICIAN: \_\_\_\_\_

PHYSICIAN ADDRESS: \_\_\_\_\_

PHYSICIAN PHONE: \_\_\_\_\_

MEDICAL CONDITION: \_\_\_\_\_

KNOWN ALLERGIES: \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

(PARENT/GUARDIAN)

Subscribed and sworn before me, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
Notary Public