WSYSA
BLACKHILLS FOOTBALL CLUB
The Select Club of DYSA

Team _____

MEDICAL RELEASE FORM

As the parent/legal guardian of _____, I request that in my absence the above named player be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named player.

Date of Player's Birth _____/_____/_____ (Month / Day / Year) Date of last Tetanus booster _____/_____/_____ (Month / Day / Year)

Known allergies of this player, including any allergies to medicine

_____

Medications regularly taken by player

_____

Any other medical problems which should be noted.

_____

Family Physician _____ Phone ( ) _____

Name of Parent/Guardian _____

Address _____ City _____ State _____ Zip _____

Phone (home) _____ (work) _____ (cell) _____

Person responsible for charges (if different from above) _____

Address _____ City _____ State _____ Zip _____

Phone (home) _____ (work) _____ (cell) _____

Person to notify if parent/guardian is unavailable _____

Phone (home) _____ (work) _____ (cell) _____

Insurance Carrier _____ Policy Number _____

Signature of Parent/Guardian _____ Date _____

Signature of Notary: _____

STATE OF Washington _____ COUNTY OF Thurston _____

Sworn to and subscribed before me on the _____ day of _____, 2006

Notary Public in and for the State of _____ Commission expires _____