MEDICAL RELEASE FORM

This is to certify that my son / daughter, _____, has my permission to participate in the STYSA Regular Season and/or Invitational Tournament. As the parent or legal guardian of the above named player, I request that in my absence, the above named player be admitted to any hospital or medical facility for diagnosis or 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 named minor. I have not been given a guarantee as to the results of the examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above named person.

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EMERGENCY INFORMATION

Date of Child's Birth ____/____/____ Date of Last Tetanus Booster ____/____/____

Known Allergies of Child (including medication) _____

My child has the following medical problem(s) which should be noted:_____

_____

Family Physician _____ Phone Number (____)_____

Next of Kin to Notify _____ Phone Number (_____)_____

Close Friend _____ Phone Number (_____)_____

Person Responsible for Charges _____

Street Address or P.O. Box _____

City, State, Zip Code _____

Phone Number (_____)_____Work PhoneNumber (_____)_____Home

PhoneNumber (_____)_____Cell

Primary Insurance Carrier _____

Policy Number _____

Secondary Insurance Carrier _____

Policy Number _____

In witness of my/our consent and agreement to the medical authorization specified herein, I/we have subscribed my/our signatures on this _____ day of _____, 20 __11__ .

_____ _____

Parent / Guardian Signature Parent / Guardian Printed Name

State of Texas
County of _____

This instrument was acknowledged before me on the _____ day of _____, 20__11__ ,

by _____.

NOTARY SEAL _____

Notary Public Signature