

# **PENNINE UTD.**

(division of The Edge Sports Academy, Inc.)

## **MEDICAL RELEASE FORM**

As parent/legal guardian of \_\_\_\_\_, I request that in my absence the above 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 minor above. 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.

Player's Date of Birth \_\_\_\_\_ Date of last Tetanus Booster \_\_\_\_\_  
Known allergies of this player, including any allergies to medicine:

\_\_\_\_\_

Any other Medical problems should be noted: \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone No: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

City,State,Zip: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Person responsible for Charges: \_\_\_\_\_

Address: \_\_\_\_\_

City,State,Zip: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Fax) \_\_\_\_\_

Person to notify if parent or guardian is unavailable: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Policy No: \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

Sworn to and subscribed before me on the \_\_\_ day of \_\_\_\_\_, 20\_\_

\_\_\_\_\_

Notary Public in and for the State of \_\_\_\_\_

Commission Expires \_\_\_\_\_