Shelton American Little League Baseball.

Medical Release

Player:_________________________Date of Birth:______________________

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 Responder. E.R. Physician).

Family Physician:___________________________ Phone:_______________
Address:____
_
Hospital Preference:____
In case of emergency, contact:
____
Name phone relation
____
Name phone relation
Please list any allergies/medical problems, including those requiring maintenance medication, (i.e. Diabetic, Asthma, Seizure Disorder)
Medical Diagnosis Medication Dosage
Frequency of dosage
____
____
____
____

The purpose of the above listed information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.

Date of last Tetanus Toxoid Booster:_____________________

Mr/Mrs.____
Parent/Guardian Signature