Little League® Baseball and Softball

M E D I C A L R E L E A S E

NOTE: To be carried by any Regular Season or Tournament Team Manager together with team roster or eligibility affidavit.

Player: _____ Date of Birth: _____ Gender _____

Parent(s)/Guardian Name: _____ Relationship: _____

Parent(s)/Guardian Name: _____ Relationship: _____

Player's Address: _____ City: _____ State/Country: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

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: _____

Parent Insurance Co: _____ Policy No.: _____ Group ID#: _____

League Insurance _____ Policy No.: _____ League/Group ID#: _____

If parent(s)/Guardian cannot be reached in case of emergency, contact:

_____

Name Phone Relationship to Player

_____

Name Phone Relationship to Player

Plase list any allergies/medical problems, including those requiring maintenance medication, (i.e. Diabetic, Asthma, Seizure Disorder)

Medical Diagnosis	Medication	Dosage	Frequency of Dosage

Medical Comments:

Date of last Tetanus Toxoid Booster: _____

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.

Mr./Mrs./Ms. _____ _____

Authorized Parent/Guardian Signature Date

FOR LEAGUE USE ONLY:

League Name: _____ League ID: _____

Division: _____ Team: _____ Date: _____

WARNING: PROTECTIVE EQUIPMENT CANNOT PREVENT ALL INJURIES A PLAYER MIGHT RECEIVE WHILE PARTICIPATING IN BASEBALL/SOFTBALL

Little League Baseball does not limit participation in its activities on the basis of disability, race, color, creed, national origin, gender, sexual preference or religious preference.