



Player Medical Release

Fax: (801) 255-5344 • Tel: (801) 255-5343 • Web: www.utahlax.org

Please fill out and return to your Coach

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 to the above minor. I have not been given a guarantee as to the results of any 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 ____/____/____ Date of last tetanus booster ____/____/____

Known allergies of this player, including any allergies to medicine _____

Any other medical problems that should be noted _____

Family Physician _____ Phone(____) _____

Name of Parent or Guardian _____

Address _____

City/State/Zip _____

Phone _____ (home) _____ (work) _____ (fax)

Person responsible for charges (if different from above) _____

Address _____

City/State/Zip _____

Phone _____ (home) _____ (work) _____ (fax)

Person to notify if parent/guardian is unavailable _____

Address _____

City/State/Zip _____

Phone _____ (home) _____ (work) _____ (fax)

Insurance Carrier _____ Policy # _____

Signature of Parent/Guardian _____ Date _____

Signature of Witness _____ Date _____

Print Name of Witness _____

Address _____

City/State/Zip _____

Phone _____ (home) _____ (work) _____ (fax)