



Little League® Baseball and Softball Medical Release



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

Player Name: _____ Date of Birth: _____ Gender (M/F) _____

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

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

Player's Address: _____ City: _____ Province: _____ Postal Code: _____

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

Parent & 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: _____ City: _____ Province: _____ Postal Code: _____

Hospital Preference: _____

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

League Insurance Co: _____ 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

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

Medical Diagnosis	medication	dosage	frequency of dosage

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

FOR LEAGUE USE ONLY:

League Name: _____ League ID: _____

Division: _____ Team: _____ Date: _____