Bison Baseball
Medical Release

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

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

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

Player's Address:_____City:_____State:_____ Zip:_____

Home Phone:_____ Mom's Cell:_____Dad's Cell:_____

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 (ie..EMT, First Rsponder, E.R., Physician)

Family Physician:_____ Phone:_____

Address:_____ City:_____ State:_____

Hospital Preference:_____

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

Add. Insurance Co:_____ Policy No:_____Group ID#:_____

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

Name:_____ Phone:_____Relation:_____

Name:_____ Phone:_____Relation:_____

Please list any allergies/medical problems, incliding those requring maintenance medications (ie..diabetic, Asthma, ADHD, Seizure Disorder)			
Medical Diagnosis	Medication	Dosage	Frquency of Dose

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._____ Date:_____
Authorized Signature

WARNING: Protective Equipment cannot prevent all injuries a player might receive while participating in Baseball.