

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 International Tournament affidavit.

Player:	Date of Birth:	Gende	er (M/F):	
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 LEGAL GUARDIAN AUTHORIZATION:		Email:		
In case of emergency, if family ph Emergency Personnel. (i.e. EMT, F	ysician cannot be reached, I hereby au First Responder, E.R. Physician)	thorize my child to l	oe treated by Certified	
Family Physician:		Phone:		
Address:	City:	State/Country:		
Hospital Preference:				
Parent Insurance Co:	Policy No.:	Group ID#:		
League Insurance Co:	Policy No.:	League/Group ID#:		
If parent(s)/legal guardian canno	ot be reached in case of emergency, co	ontact:		
Name	Phone	Relationship to Player		
Name	Phone	Relationship to Player		
Please list any allergies/medical pro	oblems, including those requiring maintena	ance medication. (i.e. I	Diabetic, Asthma, Seizure Disorder)	
Medical Diagnosis	Medication	Dosage	Frequency of Dosage	
	l			
	er:			
	n is to ensure that medical personnel have details	of any medical problem w	hich may interfere with or alter treatmen	
Mr./Mrs./Ms Authorized Par	rs./MsAuthorized Parent/Guardian Signature		Date:	
FOR LEAGUE USE ONLY:				
League Name:		League ID:		
Division:	Toame		Data	