



SOUTHWEST PORTLAND LITTLE LEAGUE

A PROGRAM OF SERVICE TO YOUTH

Medical Release



Full Legal Name of Player: _____ Birth Date: _____

Printed Name of Legal Guardian(s): _____

Mailing Address: _____

Phone (H) _____ (W) _____ (Cell) _____ (Fax) _____

In case of emergency contact:

| Name | Phone number | Relationship |
|-------|--------------|--------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

| Name | Phone Number | Relationship |
|-------|--------------|--------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Please list any allergies or medication reactions: _____

Is the above-named player currently taking any prescribed medications? (Circle one) YES NO

If you answered "YES", please explain: _____

Date of last Tetanus booster: _____

Family Physician: _____ Phone: _____

Address: _____ Hospital Preference: _____

Health Insurance Provider: _____ Policy #: _____

Employer: _____ ID #: _____

PARENT/GUARDIAN EMERGENCY TREATMENT AUTHORIZATION:

By signing below, I/We hereby authorize Mt Sylvania Little League official(s), in the case of a medical emergency where neither myself/ourselves nor our child's primary physician (named above) is available, to authorize another medical care provider to provide emergency treatment to the above-named player.

Signature(s): _____ Date: _____