

CRUSH KICKBALL MEDICAL RELEASE FORM

Player's Name: _____ Date of Birth: _____ Gender: _____

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

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

Player's Address: _____

City: _____ State: _____ Zip code: _____

PARENT/GUARDIAN CONTACT INFORMATION:

Email: _____ Phone: _____

PHYSICIAN/HOSPITAL/INSURANCE INFORMATION:

Physician: _____ Phone Number: _____

Address: _____

Hospital Preference: _____

Insurance Company: _____ Policy #: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Please list any medical diagnosis, allergies, or other medical problems, including those requiring maintenance medication (i.e., diabetic, asthma, seizure disorder):

Medications: _____

PARENT/GUARDIAN AUTHORIZATION:

I/we hereby grant consent to any and all health care providers to administer any necessary medical care as a result of injury/illness. This consent includes First Aid and transportation to/from health care providers. Further, I will assume all financial responsibility for the medical bills incurred on behalf of my child.

Authorized Parent/Guardian Signature

Date

