2018 Centralia Girls Softball Association

MEDICAL RELEASE FORM

Player Name: ____

To Whom It May Concern:

The bearer of this form has permission to authorize necessary emergency medical care by the attending physician, emergency medical staff, or others he/she may choose, in case of accidental injury, ingestion, or illness.

Home Address: ____

Home Phone: ____________________________ Date of Birth: ______________________

Insurance Company: ____

Plan or Group #: ___________________ Policy/Membership #: ______________________

Employer: ____

Allergies, Other Medical Concerns and/or Special Instructions: ______________________

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Mother's Name: ____

Mother's Cell Number: ____

Father's Name: ____

Father's Cell Number: ____

In case of an accident or illness, I hereby authorize a representative of the Centralia Girls Softball Association to use his/her judgment in obtaining immediate medical care for the above named child.

____ ___________________________

Signature of Parent/Guardian Date