THE BASEBALL CENTER NYC

MEDICAL RELEASE

Player: ________________________________ **Date of Birth:** ________________________________

Address: ________________________________ **Home Phone:** ________________________________

City_____________________________________ **State/Zip:** ________________________________

Parent or Guardian Authorization:

In Case of emergency, Contact:

____

Name: Phone: Relationship to Child

____

Name: Phone: Relationship to Child

In case of emergency, if family physician cannot be reached, I/WE authorize my child to be treated by Certified Emergency Personnel (i.e. EMT, Emergency Room Physician).

Family Physician: ________________________ Phone: ______________________________________

Physicians Address: ____

Hospital Preference: ____

Insurance Carrier & Policy Number: ____

Please list any allergies/medical problems, including those requiring maintenance medication (i.e. Diabetic, asthma, Seizure Disorder, Food Allergies, Bee Stings, etc.

Medical Condition	Medication	Dosage	Frequency of dosage

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.

Date of last Tetanus Toxoid Booster:______________________

____

Mr./Mrs. (Authorized Parent or Guardian Signature) Date

WARNING: Protective equipment cannot prevent all injuries a player might receive while participating in Sports Activities

202 West 74th Street, New York, New York 10023

Phone 212-362-0344 www.thebaseballcenternyc.com Fax 212-362-2413