HARWINTON YOUTH SPORTS ASSOCIATION

MEDICAL RELEASE

NOTE: TO BE CARRIED WITH ANY REGULAR SEASON OR TOURNAMENT TEAM MANAGER TOGETHER WITH TEAM ROSTER OR ELIGIBILTY AFFIDAVIT

Player: ________________________________ D.O.B. _______________

HYSA Sport: _________________________ Date: _______________

In case of emergency, if family physician cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel (i.e. EMT, First Responder, E.R. Physician)

Family Physician: ______________________________ Phone: ______________

Address: ____

Hospital Preference: ____

In case of Emergency contact:

Name:________________________________Phone:________________Relationship to Player:_______________

Name:________________________________Phone:________________Relationship to Player:_______________

Please list any allergies/medical problems, including those requiring maintenance medication. (i.e. Diabetic, Asthma, Seizure Disorder)

Medical Diagnosis	Medication	Dosage	Frequency of Dosage

The purpose of the above listed information is to ensure that the medical personnel have details of any medical problem which may interfere with or alter treatment.

Tetanus Toxoid Booster: UP TO DATE_____ OUT OF DATE _____ NOT SURE _____

Parent/Legal Guardian: ______________________________________Date:___________

******PROTECTIVE EQUIPMENT CANNOT PREVENT ALL INJURIES A PLAYER MIGHT RECEIVE WHILE PARTICIPATING IN YOUTH ATHLETICS******