GREAT FALLS

LACROSSE

Medical Release Form

I hereby give permission for any and all medical attention necessary to be administered to my child, whose name appears below, in the event of an accident, injury, sickness, etc. under the direction of the person(s) listed below, until such time as I may be contacted. This release is effective until revoked by me. I also hereby assume the responsibility for payment for such treatment.

Child's Name: _____ Team: _____

Parents: _____

Address: _____

Home Phone: _____ Other Phone: _____

Medical Insurance: _____

Policy Number: _____

In case I cannot be reached, any of the following is designated to act in my place:

Coach: _____ Phone: _____

Manager: _____ Phone: _____

Other: _____ Phone: _____

Physician: _____ Phone: _____

Physician Address: _____

Known Allergies: _____

Signature (Parent) _____