FC WISCONSIN NATIONALS MEDICAL RELEASE FORM

As the parent/guardian of_____, I request that in my absence, the above named player be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine, Doctors of Dentistry or other such licensed technicians or nurses, to perform and diagnostic procedures, treatment procedures, operative procedures, and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named player.

Date of Player's Birth___/___/____Date of last Tetanus Booster___/___/____.
month day year month day year

Known allergies of this player, including any allergies to medicine

_____

Any other medical problems which should be noted

_____

Family Physician_____Phone _____

Name of Parent/Guardian _____

Address _____

City/State/Zip _____

Phone_____H_____W

Person to notify if parent /guardian is unavailable _____

Phone_____H_____W

Insurance Carrier_____Policy Number _____

Signature of Parent/Guardian _____