# GA Impact
# Medical Release Form

As the parent or legal 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 or Doctors of Dentistry or other such licensed technicians or nurses, to perform any 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.

## Player Information

Player Name_____Age Group_____

DOB____/_____/_____ Date of last Tetanus booster____/_____/_____ ☐ Male ☐ Female

Known medical problems or allergies, including any allergies to medicine_____

_____

Player's Physician_____Phone_____

Address_____

## Parent/Guardian Information

Parent/Guardian Name(s)_____Home Phone_____

Address_____

Cell (M)_____Cell (F)_____Work (M)_____Work (F)_____

Person responsible for charges (if different from above)_____

Address_____Phone_____

Insurance Carrier_____Policy #_____

## Emergency Contacts

In case I cannot be reached, the following are designated to act on my behalf:

Coach Name_____Phone_____

Assistant Coach/Team Manager_____Phone_____

Other emergency contact_____Phone_____

OR: A Cherokee Impact league representative where my child is playing; a tournament representative where my child is participating in such tournament.

**Parent Signature**_____**Date**_____