Connie Mack® Baseball
M E D I C A L R E L E A S E

NOTE: To be carried by any Regular Season or Tournament
Team Manager together with team roster or Tournament affidavit.

Player: _____ Date of Birth: _____ Gender (M/F):_____

Parent (s)/Guardian Name:_____ Relationship:_____

Parent (s)/Guardian Name:_____ Relationship:_____

Player's Address:_____ City:_____ State/Country:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Mobile Phone:_____

PARENT OR LEGAL GUARDIAN AUTHORIZATION: Email: _____

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: _____ City:_____ State/Country:_____

Hospital Preference: _____

Parent Insurance Co:_____ Policy No.:_____Group ID#:_____

League Insurance Co:_____ Policy No.:_____League/Group ID#:_____

If parent(s)/legal guardian cannot be reached 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

Date of last Tetanus Toxoid Booster: _____

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.

Mr./Mrs./Ms. _____
Authorized Parent/Guardian Signature Date:

FOR LEAGUE USE ONLY:

League Name:_____ League ID:_____

Division:_____Team:_____ Date:_____

WARNING: PROTECTIVE EQUIPMENT CANNOT PREVENT ALL INJURIES A PLAYER MIGHT RECEIVE WHILE PARTICIPATING IN BASEBALL. Connie Mack does not limit participation in its activities on the basis of disability, race, color, creed, national origin, gender, sexual preference or religious preference.