Hornets Baseball

New England A.A.U

Emergency Medical Release Form

PLAYER INFORMATION

Player Name____ Birth date________
First Middle Last

Home Address____
City State Zip

PARENT/GUARDIAN INFORMATION

Custodial parent/guardian____________________________ Home Phone ________________

Cell Phone ________________________ Work Phone ______________________

Home Address____
(If different from above) City State Zip

Second parent/guardian____________________________ Home Phone ________________

Cell Phone ________________________Work Phone______________________

Home Address____
(If different from above) City State Zip

EMERGENCY CONTACT

If parents are not available in an emergency, notify:

Name_______________________________________ Home Phone ________________

Cell Phone________________________Work Phone______________________

Relationship to player_____________________________

PERMISSION TO PROVIDE TREATMENT

I hereby give permission to the Hornets Developmental Baseball Program Coaches to seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the Hornets Developmental Baseball Program Coaches to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Hornets Developmental Baseball Program Coaches to secure and administer treatment, including hospitalization, for the person named on the previous page. This completed form may be photocopied.

Parent/Guardian Signature Required for Hornets Developmental Baseball Program.

**Signature of parent or guardian____Date__________

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INSURANCE INFORMATION

Is the player covered by family medical/hospital insurance? ___Yes ___ No

If so, indicate carrier or plan name____ Group # ___________________

Carrier Address____

Name of Insured____ Relationship to player_____________________

ALLERGIES

7 No known allergies.

List all known. Describe reaction and management of the reaction

____________________ ____

____________________ ____

Food Allergies

____________________ ____

____________________ ____

Other Allergies: Include Insect stings, hay fever, asthma, animal dander, etc.

____________________ ____

____________________ ____

MEDICATIONS

7 This person takes no prescribed or over the counter medications.

Please list ALL medications that the player is currently taking, (including over the counter medications.)

Medicine # 1___________________________ Dosage_________ Times taken each day_____________

At what time of the day is this medication taken ____

Medicine # 2___________________________ Dosage_________ Times taken each day_____________

At what time of the day is this medication taken ____