Perseverance Athletics

Medical Release Form

NAME: _____DOB: _____ SEX: m / f

Mother's Name: _____ Father's Name: _____

Hm Phone: _____Wk Phone: _____ Cell Phone: _____

If the person(s) above are not available, in the event of an emergency, please notify:

Name: _____Relationship: _____Phone: _____

Name: _____Relationship: _____Phone: _____

Name of personal Physician: _____Phone: _____

Insurance Company: _____Policy #:_____

In case of an emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the physician selected to secure the proper medical treatment which may include hospitalization, anesthesia, surgery or injection of medication for my son/daughter.

_____ _____

Signature of Parent/Guardian Date

Medical Information past or present: (Please Circle)

Asthma	Heart Disease	Leukemia	Allergies	Cancer
Diabetes	Seizures	Hemophilia	High Blood Pressure	

If circled, please explain: _____

_____

Allergies to Medications/Food/Insect Bites/Plants: _____

Do you wear glasses or contacts?

Date of last Tetanus Shot: _____