



BAY STATE THUNDER Medical Release Form



(PLEASE PRINT ALL REQUESTED INFORMATION)

NOTE: *To be carried by any regular season or Tournament Team Manager together with team roster or eligibility affidavit.*

PLAYER NAME: _____ DATE OF BIRTH: _____

PARENT OR GUARDIAN AUTHORIZATION:

In case of emergency, if family physician cannot be reasonably reached, I hereby authorize my child to be treated by Certified Emergency Personnel (i.e. EMT, First Responder, E.R. Physician or comparable)

FAMILY PHYSICIAN: _____ PHONE (_____) _____

ADDRESS: _____

HOSPITAL PREFERENCE: _____

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

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

DATE OF LAST TETANUS TOXOID BOOSTER: _____

MR./MRS. _____
AUTHORIZED PARENT/GUARDIAN SIGNATURE

WARNING: Protective equipment cannot prevent all injuries a player might receive while participating in Softball. The **BAY STATE THUNDER** program does not limit participation in its activities on the basis of disability, race, color, creed, national origin, gender or religious preference.