The Ray Gallant Baseball Tournament
M E D I C A L R E L E A S E
AUGUST 2017 TOURNAMENT

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 GUARDIAN AUTHORIZATION:

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)/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 TOURNAMENT USE ONLY:

League Name: _____ MGR_____

WARNING: PROTECTIVE EQUIPMENT CANNOT PREVENT ALL INJURIES A PLAYER MIGHT RECEIVE WHILE PARTICIPATING IN BASEBALL