Cruzeiro Academy
Chicago, IL - USA

MEDICAL RELEASE FORM

As the parent/legal guardian of _____, I request that in my absence the above named player be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of any examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above named player.

Date of Player's Birth ____/____/_____ Date of last tetanus booster____/____/_____

Known allergies of this player, including any allergies to medicine

_____

Any other medical problems that should be noted

_____

Family Physician _____ Phone_____

Name of Parent of Guardian

_____

Address_____

City/ State/ Zip

_____

Phone (H)_____(W)_____

Email Address_____

Person responsible for charges (if different from above)
_____
Address_____
City/ State/ Zip
_____

Phone _____

(H)_____(W)_____Email_____

Person to notify if parent/guardian is unavailable
_____

Address_____

City/ State/ Zip
_____

Phone _____

(H)_____(W)_____Email_____

Insurance Carrier_____Policy#_____

Signature of
Parent/Guardian_____

State of _____

County of_____

Sworn to and subscribed before me on the _____ day of _____, _____

_____

Notary Public in and for the State of _____
Commission Expires _____

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