PRoBASEBALL HIGH SCHOOL MEDICAL FORM

As a 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, pain relief measures and x-ray treatment of the above player. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility and its staff to share information on the medical condition of my child with the parent, coach or assistant coach associated with his baseball team that represent him/herself as the responsible adult in my absence.

Players Date of Birth ____/____/_____ Date of last Tetanus booster ____/____/____

M / D / YEAR M / D / YEAR

Known Medical Problems/Allergies _____

Name of Parent/Guardian _____

Address _____

Home Phone: _____ Work (Mother) _____ Work (Father) _____

Mobile Phone (Mother) _____ Mobile Phone (Father) _____

Emergency Contact Name (If parents is unavailable) _____

Home Phone _____ Work Phone _____ Mobile Phone _____

Family Physician _____

Physician Address _____

Insurance Carrier _____ Policy Number _____

Insurance Address _____

Signature of Parent/Guardian _____ Date _____