

**Lakewood Junior Baseball Association
Medical Release Form**

Athlete's Name: _____ Birth Date: _____

Street Address: _____ City: _____

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

Work Phone: _____ Work Phone: _____

Home Phone: _____ Home Phone: _____

Cell Phone: _____ Cell Phone: _____

Doctor's Name: _____ Phone: _____

Does Athlete wear contacts? _____

Dentist's Name: _____ Phone: _____

Hospital Preference: _____

Insurance Provider: _____

Insurance Coverage in the Name of: _____

Allergies to Medications: _____

Medications Currently Being Taken (list): _____

Known Allergies and/or Medical Conditions: _____

Emergency Contact (other than parents): _____ Phone: _____

Permission is hereby granted to managing personnel to authorize and obtain medical and/or dental care or treatment from any licensed physician, hospital, or medical clinic should my child become ill or injured while participating in Lakewood Junior Baseball, league or team activities away from home, or at other times when neither parent or legal guardian is available to authorize emergency treatment.

Signed (Parent or Legal Guardian): _____ Date: _____