

Medical Release

**(Emergency Information and Consent)
(One for Each Youth)**

Athlete/Participant's Name _____ Nickname _____

Address _____

Phone _____

Father's/Mother's/Legal Guardian's

Address _____

Home Phone _____

Work Phone _____

Cell Phone _____

Family Medical Insurance

Carrier _____

Group _____

Policy # _____

Group# _____ ID# _____

Family Physician's Name _____

Address _____

Phone _____

Alternate # _____

Allergies: (list) _____

Serious Medical Condition _____

I/we hereby grant consent to any and all health care providers designated by:

_____ Ohio Pal/Willoughby Pal _____

To provide my child _____ any necessary medical care as a result of any injury/illness. This consent includes First Aid and transportation to/from health care providers.

Date

Father's Signature/Legal Guardian's Signature

Date

Mother's Signature/Legal Guardian's Signature