WEST TEXAS YOUTH BASEBALL LEAGUE
MEDICAL RELEASE FORM
COACHES KEEP THIS FORM AT ALL TIMES

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 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 examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named player.

DOB_______/_______/_________.

Known Allergies____
Any other medical problems which should be noted:______________________________________
Family Physician:_________________________Phone: (_____) ____________________________

Parent/Legal Guardian____
Street Address: ____
City: _____________________State:__________________Zip:______________________________
Phone #'s: Home:________________Work:_____________Cell:______________________________

Person responsible for charges: ____
Street Address: ____
City:______________________State:__________________Zip:______________________________
Phone #'s: Home:________________Work:______________Cell:_____________________________

Person to notify if parent/Legal guardian is not able to be reached: __________________________
Street Address: ____
City:_____________________State:_________________Zip:_______________________________
Phone #'s: Home:_______________Work:_____________Cell:______________________________

Name of parent/Legal guardian: ____

Parent/Legal Guardian: ________________________________ ______________________
Signature Date