

**CHAMPIONS SHOWCASE
MEDICAL RELEASE FORM**

As the parent/legal guardian of:

Name of Player: _____

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

Players birth date: _____ (month) _____ (day) _____ (year)

Allergies: _____

Other Medical Conditions: _____

Name of Parent/Guardian: _____

Street Address: _____ City: _____ Prov: _____

Zip Code: _____ Phone # H: () - _____ Work #: () - _____

Person to notify if parent/guardian is unavailable: _____

Phone # : _____

Signature of Parent /Guardian: _____ Date: _____