

## Medical Release

Youth's name \_\_\_\_\_

Address \_\_\_\_\_

Birth date / / Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

Emergency person and phone: \_\_\_\_\_  
( ) \_\_\_\_\_ - \_\_\_\_\_

I (we) understand that in the event medical treatment is required, every effort will be made to contact me. However, if I cannot be reached, I give my permission to the staff or sponsor to secure the services of a licensed physician to provide the care necessary, including anesthesia for my child's well-being.

Signed: (x) \_\_\_\_\_  
Date: / / (Parent or Guardian)

Please list any medical allergies, medications being taken, medical problems. Or other pertinent information:

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