Little League® Baseball and Softball
Medical Release

NOTE: To be carried by any Regular Season or Tournament Team Manager together with team roster or eligibility affidavit.

Player: _____ Date of Birth: _____

League Name: _____ I.D. Number: _____

Parent or Guardian Authorization:

In case of emergency, if family physician cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel. (i.e. EMT, First Responder, E.R. Physician)

Family Physician: _____ Phone: _____

Address: _____

Hospital Preference: _____

In case of emergency contact:

_____
Name Phone Relationship to Player

_____
Name Phone Relationship to Player

Please list any allergies/medical problems, including those requiring maintenance medication. (i.e. Diabetic, Asthma, Seizure Disorder)

Medical Diagnosis	Medication	Dosage	Frequency of Dosage

The purpose of the above listed information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.

Date of last Tetanus Toxoid Booster: _____

Mr./Mrs./Ms. _____
Authorized Parent/Guardian Signature

WARNING: Protective equipment cannot prevent all injuries a player might receive while participating in Baseball/Softball.

Little League does not limit participation in its activities on the basis of disability, race, color, creed, national origin, gender, sexual preference or religious preference.

LEWISTOWN HOSPITAL
A SERVICE OF LEWISTOWN HEALTHCARE FOUNDATION
400 HIGHLAND AVENUE LEWISTOWN, PA 17044 (717) 248-5411

AUTHORIZATION FOR CONSENT TO MEDICAL TREATMENT FOR A MINOR

(IMPRINT NAME PLATE HERE)

I / We _____ (Parent / Guardian Name) and _____ (Parent / Guardian Name) of _____ (City), _____(County), _____ (State), do hereby state that I am / we are the natural parents (legal guardians) having legal custody of _____ (Child's name), a minor, age ____, _____ (date of birth), who resides with me / us at _____ (street address). I authorize _____ (name), an adult, who resides at _____ (address), in the city of _____, county of _____, state of _____, or _____ (name), an adult, who resides at _____ (address), in the city of _____, county of _____, state of _____, to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to the above-named minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the State of _____, when the need for such treatment is immediate, and when the efforts to contact me / us are unsuccessful.

Dated this _____ (day) of _____ (month), _____ (year).

_____
(Signature of Parent or Guardian)

_____
(Expiration Date)

Child's Allergies: _____

_____

_____

Medicines child is taking _____

_____

_____

Home Phone: (___) _____

Work Phone: (___) _____

Child's Doctor_____

Parent's Doctor_____

Choice of Specialist(s) (if available)

_____

_____

Date of last tetanus shot _____

Baby shots - (up to date) _____

(Not up to date) _____

If not up to date, list shots the child has had:

_____

_____

_____