

Special Needs Sports Health and Medical Release Form

Players' name: _____ DOB: _____

Family Physician: _____ Phone #: _____

Name of Parent or legal guardian: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Company: _____ Policy #: _____

Phone #: _____ Cell #: _____

Person to notify if parent/guardian is unavailable: _____

Phone #: _____ Cell #: _____

Health Information (please check all that apply):

- Asthma ADHD/ADD Atlanto-axias Instability Autism Bleeding Problems Diabetes
 Down Syndrome Emotional Problems Fainting Spells Hepatitis Hearing Impaired
 Heart Problems Learning Disabilities Non-verbal (signs) Seizure Disorder
 Spectrum Disorder Visually Impaired Others: _____

Allergies (include medications): _____

List Aids Used (wheel chairs hearing aids, glasses etc): _____

Medications: _____

List any other information about your child that the coaching staff needs to be informed about: _____

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 Doctors of Dentistry or other licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named player. I have not been given a guarantee as to the results of examination or treatment.

I hereby represent _____ that he/she has my permission to participate in the Special Needs Sports program

Parent/Guardian signature: _____ **Date:** _____