Little League® Baseball and Softball
M E D I C A L R E L E A S E

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

Player: _____ Date of Birth: _____ Gender (M/F):_____

Parent (s)/Guardian Name:_____ Relationship:_____

Parent (s)/Guardian Name:_____ Relationship:_____

Player's Address:_____ City:_____ State/Country:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Mobile Phone:_____

PARENT OR LEGAL GUARDIAN AUTHORIZATION: Email: _____

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: _____ City:_____ State/Country:_____

Hospital Preference: _____

Parent Insurance Co:_____ Policy No.:_____Group ID#:_____

League Insurance Co:_____ Policy No.:_____League/Group ID#:_____

If parent(s)/legal guardian cannot be reached 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

Date of last Tetanus Toxoid Booster: _____

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.

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

FOR LEAGUE USE ONLY:

League Name:_____ League ID:_____

Division:_____Team:_____ Date:_____

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.