Little League Baseball®
Medical Release

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

Player Name: _____ Date of Birth: _____

Family Physician: _____ Phone: _____

Home Address: _____ Mobile Phone:_____

Hospital Preference: _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

_____	_____	_____
Name	Phone	Relationship to Player
_____	_____	_____
Name	Phone	Relationship to Player

Please list any allergies/medical problems, including those requiring maintenance/ emergency medication. (i.e. Diabetes, Asthma, Seizure Disorder, food/bee/other allergies, etc.)

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: _____

History of Concussions (list dates): _____

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)

Mr./Mrs./Ms. _____

Authorized Parent/Guardian Signature

Parent/Guardian Name (print)_____

Relationship to Player _____

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

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