Orange County Youth Tennis Camp
M e d i c a l R e l e a s e

.

Child's Name: _____ Date of Birth: _____ Gender (M/F):_____

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

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

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

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

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: _____ City:_____ State/Country:_____

Hospital Preference: _____

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

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

if parent(s)/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: