DIAMOND DEVILS BASEBALL PROGRAM

MEDICAL RELEASE FORM

PLAYERS NAME:_____

ADDRESS:_____

CITY:_____STATE:_____ ZIP:_____

HOME PHONE:_____ CELL PHONE:_____

My son has permission to participate in the Diamond Devils Baseball Program.

_____

Signature of Parent or Legal Guardian **Date**

EMERGENCY CONTACT INFORMATION:

Hm. Phone:_____ Cell Phone:_____ Wk. Phone:_____

Other Authorized Adult:_____

Relationship:_____Phone Number:_____

Physician's Name:_____ Phone:_____

Insurance Company :_____

Policy Number:_____

I understand that the participant's insurance plan is the primary carrier and the Program's insurance carrier is secondary.

Special Medical Considerations:

_____

_____

(List all allergies to medicine or foods, physical conditions, and any other medical consideration of which the Program should be made aware.)

I hereby authorize Diamond Devils Baseball Program through the adult person in charge, my consent to perform any emergency care (x-ray, anesthetic, medical, or surgical diagnosis or treatment) or hospital care for my son, under supervision of a licensed physician. The Diamond Devils Baseball Program should be immediately notified of any changes or additions to this Medical Release Form. This authorization shall remain in effect throughout the activity period.

_____

Signature of Parent/Legal Guardian **Date**

ALL PARTICIPANTS MUST ALSO SIGN THE INDIVIDUAL RELEASE AND HOLD-HARMLESS AGREEMENT .