



# MEDICAL CONSENT/ RELEASE FORM

As the parent/legal guardian of \_\_\_\_\_, I request that in my absence the above named **CALIFORNIA SPIN FASTPITCH CHILD/PLAYER or ADULT** be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, nurses, dentists and staff, to perform any diagnostic procedures, treatment procedures, and operative procedures to the above named individual. I have not been given any guarantee as to the results of any treatment if performed on the above named individual. I hereby accept any financial responsibility for any and all medical treatment necessary to be administered to the above named **CALIFORNIA SPIN FASTPITCH CHILD/PLAYER or ADULT** in the event of an accident, injury, sickness, etc.

Any representative of the following organization is designated to act in my behalf until I have been contacted: **CALIFORNIA SPIN FASTPITCH**  
Or

The following individual is designated to act in my behalf until I have been contacted:

\_\_\_\_\_

### GENERAL RELEASE

I understand the above named **CALIFORNIA SPIN FASTPITCH CHILD/PLAYER or ADULT** assumes any and all risks that might be associated with the activities that he or she may be involved in and release all rights and claims for damages which the above named **CALIFORNIA SPIN FASTPITCH CHILD/PLAYER or ADULT**, heirs, executors, administrators assign, or as I may have against **CALIFORNIA SPIN FASTPITCH SOFTBALL**, its directors, coaches, officials, teachers or representatives for any and all injuries or damages of any kind as a result of their participation.

Date of Birth: \_\_\_/\_\_\_/\_\_\_ for the above named individual.

Date of last Tetanus Booster: \_\_\_/\_\_\_/\_\_\_ for the above named individual.

Known allergies and reactions of the above named individual, including any allergies to medicine:

\_\_\_\_\_

Any other special medical problems that should be noted about the above named individual:

\_\_\_\_\_

Any medications that the above named individual will be bringing with them:

\_\_\_\_\_

Family Physician: \_\_\_\_\_

Phone number: \_\_\_\_\_

Family Dentist: \_\_\_\_\_

Phone number: \_\_\_\_\_

Name of Parents/Guardians: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: H \_\_\_\_\_ W \_\_\_\_\_ Other \_\_\_\_\_

Person Responsible for charges (if different than above): \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: H \_\_\_\_\_ W \_\_\_\_\_ Other \_\_\_\_\_

Other Person to notify if parent/guardian is unavailable: \_\_\_\_\_

Phone number: H \_\_\_\_\_ W \_\_\_\_\_ Other \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy or Group Number: \_\_\_\_\_

Signature:

PARENT OR GUARDIAN: \_\_\_\_\_ DATE: \_\_\_\_\_