



## PLAYER MEDICAL RELEASE FORM

**Athlete's Name** \_\_\_\_\_

I, the undersigned Parent/Guardian of the above-named minor child participating in the sport of basketball with the WBA Lady Knicks, Inc., hereby authorize an officer, coach or agent of the WBA Lady Knicks, Inc. to transport, as required, the above mentioned athlete for any medical attention.

I hereby give my consent for said athlete to receive any and all medical care necessary to be administrated as prescribed by a duly licensed doctor under whatever conditions are necessary to preserve the life, limb, or well being of said athlete.

### ATHLETE'S INFORMATION

First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Date of Birth \_\_\_\_\_ Email \_\_\_\_\_

### PARENT/GUARDIAN INFORMATION

Mother's Name \_\_\_\_\_

Email \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Father's Name \_\_\_\_\_

Email \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

### EMERGENCY CONTACTS

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

### MEDICAL INFORMATION

Insurance Carrier \_\_\_\_\_ ID # \_\_\_\_\_

Known Allergies \_\_\_\_\_

Other Medical Information \_\_\_\_\_

SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_

PARENT/GUARDIAN NAME (print) \_\_\_\_\_