

ROCKAWAY TOWNSHIP RECREATION BOYS BASKETBALL MEDICAL RELEASE FORM

To be carried by ALL recreation coaches to games and practices

Player: _____ Date of Birth: ___ / ___ / ___

Parent/Guardian(s) Names: _____

Home address _____

Home Phone# _____ Parent/Guardian Cell# _____

Family Physician: _____ Phone: _____

Hospital Preference: _____

In Case of emergency where parent cannot be reached, please contact:

Contact Name	Home Phone	Cell Phone	Relationship to Player
1.			
2.			

Please list any allergies/medical problems, including those requiring maintenance medications.

Diagnosis	Medication	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 Booster: _____

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.

Parent/Guardian Name (print) _____

Parent/Guardian Signature _____

Electronic signatures are not acceptable, documents must be signed in ink (i.e., proof of signature)