WAGS TOURNAMENT MEDICAL RELEASE FORM

I hereby give permission for any and all medical attention necessary to be administered to whose name appears below, in the event of an accident, injury, sickness, etc. under the direction of the person(s) listed below, until such time as I may be contacted. This release is effective until revoked by me. I also hereby assume the responsibility for payment for such treatment.

PLAYER NAME: _____

TEAM NAME: _____

ADDRESS: _____

HOME PHONE: _____ **CELL PHONE:** _____

MEDICAL INSURANCE: _____

POLICY NUMBER: _____

In case I cannot be reached, any of the following is designated to act in my place:

COACH: _____ **PHONE:** _____

MANAGER: _____ **PHONE:** _____

OTHER: _____ **PHONE:** _____

PHYSICIAN: _____ **PHONE:** _____

PHYSICIAN ADDRESS: _____

KNOWN ALLERGIES: _____

SIGNATURE: _____ **DATE:** _____