ROCKAWAY TOWNSHIP RECREATION
GIRLS 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 ____________________________________