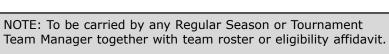


Little League Baseball_®

Medical Release





Player:		Date of Birth:	
League Name:		I.D. Number:	
Parent or Guardian Author	rization:		
In case of emergency, if facility child to be treated by Cert Physician)			
Family Physician:		Phone:	
Address:			
Hospital Preference:			
In case of emergency con	tact:		
Name	Phone	Phone	
Name	Phone	Phone	
Please list any allergies/medical problems, including those requiring maintenance medication. (i.e. Diabetic, Asthma, Seizure Disorder)			
Medical Diagnosis	Medication	Dosage	Frequency of Dosage
The purpose of the abore have details of any med	ve listed information is to ical problem which may in	ensure the	at medical personnel th or alter treatment.
Date of last Tetanus Toxoi	d Booster:		
Mr./Mrs./Ms	Parent/Guardian Signature		

WARNING: Protective equipment cannot prevent all injuries a player might receive while participating in Baseball/Softball.

Little League Baseball does not limit participation in its activities on the basis of disability, race, color, creed, national origin, gender, sexual preference or religious preference.