

**Medical Release  
(Emergency Information and Consent)  
(One for Each Youth)**

Athlete/Participant's Name \_\_\_\_\_ Nickname \_\_\_\_\_

Address \_\_\_\_\_

Phone(\_\_\_\_) \_\_\_\_\_

Father's/Mother's/Legal Guardian's

Address \_\_\_\_\_

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

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

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

Family Medical Insurance

Carrier \_\_\_\_\_

Group \_\_\_\_\_

Policy # \_\_\_\_\_

Group# \_\_\_\_\_ ID# \_\_\_\_\_

Family Physician's Name \_\_\_\_\_

Address \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Alternate # \_\_\_\_\_

Allergies: (list) \_\_\_\_\_

Serious Medical Condition \_\_\_\_\_

I/we hereby grant consent to any and all health care providers designated by:

\_\_\_\_\_  
Ohio Pal/Willoughby Pal

To provide my child \_\_\_\_\_ any necessary medical care as a result of any injury/illness. This consent includes First Aid and transportation to/from health care providers.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Father's Signature/Legal Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Mother's Signature/Legal Guardian's Signature