# Seneca Falls Junior Football and Cheerleading League
# Medical Release

Name:_____ Date of Birth_____

Team:_____

Parent or Guardian Authorization:

In case of emergency, if family Physician cannot be reached, I hearby authorize my child to be treated by Certified Emergency Personnel. (ie EMT, First Responder, ER Physician)

Family Physician:_____ Phone:_____

Address:_____

Hospital Preference:_____

In Case of Emergency contact:

| Name | Phone # | Cell Phone # | Relationship to Player |
|---|---|---|---|
| Name | Phone # | Cell Phone # | Relationship to Player |
| Name | Phone # | Cell Phone # | Relationship to Player |

Please list any medical problems and/or conditions, including those requiring maintenance medication. (ie allergies, diabetes, asthma, seizure disorder)

| Medical Diagnosis | Medication | Dosage | Frequency of Dosage/Time |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Has your child ever had a concussion, head, neck or spinal injury? Y___ N___
Explanation:_____
_____.

The purpose of the above listed information is to ensure that medical personnel have details of any medical problems, which may interfere with or alter treatment.

Date of last Tetanus Toxoid Booster:_____
Parent/Guardian Signature:_____