

**COLORADO GOLD BASKETBALL
MEDICAL RELEASE FORM**

As the parent/legal guardian of _____, I request that in my absence the above-named player be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named player.

PLAYER INFORMATION:

Player's Name: _____ Nickname: _____
Player's Address: _____ Home Phone: (____) _____
_____ Cell Phone: (____) _____

Date of Player's Birth: ____/____/____ Date of last Tetanus Booster: ____/____/____

Known allergies of this player, including any allergies to medicine: _____

Any other medical problems which should be noted: _____

FAMILY MEDICAL PROVIDERS:

Family Physician: _____ Phone: (____) _____
Physician Address: _____ Email: _____

Family Dentist: _____ Phone: (____) _____
Dentist Address: _____ Email: _____

FAMILY MEDICAL INSURANCE:

Carrier: _____ Group: _____
Policy No: _____ Group #: _____
Phone: (____) _____

PARENT/GUARDIAN INFO:

Name: _____ Home Phone: (____) _____
Address: _____ Cell Phone: (____) _____
_____ Work Phone: (____) _____

Person responsible for charges (if different from above): _____

Address: _____ Cell Phone: (____) _____
_____ Work Phone: (____) _____

Person to notify if parent/guardian is unavailable: _____

Phone: H(____) _____ W(____) _____ Cell (____) _____

Signature of Parent/Guardian _____ Date _____