



**MEDICAL INFO/RELEASE FORM**

The undersigned, as Parent or Legal Guardian of \_\_\_\_\_ hereby consents to  
 (PRINT NAME OF PARTICIPANT)  
 the following in the event he/she is injured during his/her participation in youth sports:

Agents or officials of the TBYFL and/or the NORTH TAMPA TITANS may administer first aid or arrange for transportation to a medical facility if the agent or official deems there to be an emergency. At that time, medical treatment may be given, including, but not limited to, anesthesia and emergency surgical treatment as deemed necessary by a qualified physician at the medical facility. No action shall be taken until attempt is made to contact the designated individuals at the phone number(s) listed below:

**CONTACT #1**

_____	_____
Contact Name: _____	Relationship to Participant: _____
Home Phone: _____	Work Phone: _____
	Cell Phone: _____

**CONTACT #2**

_____	_____
Contact Name: _____	Relationship to Participant: _____
Home Phone: _____	Work Phone: _____
	Cell Phone: _____

*To ensure that medical personnel have details of any medical problem which may interfere with or alter treatment, please list any allergies/medical problems, including those requiring the use of maintenance medication (e.g. Diabetes, Asthma, Seizure Disorder).*

<u>Medical Condition</u>	<u>Medication</u>	<u>Dosage/Frequency</u>

FAMILY PHYSICIAN: \_\_\_\_\_ TELEPHONE NUMBER: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ HOSPITAL PREFERENCE: \_\_\_\_\_

Parent/Guardian Printed Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_