



America's Showcase Medical Release

Name: _____ Date: _____

Address: _____ Birthdate: _____

Daytime Phone: _____ Evening Phone: _____

WHO TO CONTACT IN CASE OF AN EMERGENCY?

Name: _____ Relationship _____

Daytime Phone: _____ Evening Phone: _____

Physician's Name: _____

Daytime Phone: _____ Evening Phone: _____

Hospital of Choice: _____

PLEASE COMPLETE THE FOLLOWING:

If the answer to any of the following questions is or was yes, please describe the problem and it's implications for proper first aid treatment on a separate piece of paper.

	CIRCLE ONE		CIRCLE ONE
Head Injury	YES NO	Shoulder	YES NO
Fainting Spells	YES NO	Knee	YES NO
Convulsions/Epilepsy	YES NO	Ankle	YES NO
Neck or Back Injury	YES NO	Fingers	YES NO
Asthma YES NO Arm	YES NO	Arm	YES NO
High Blood Pressure	YES NO	Other: _____	
Kidney Problems	YES NO		
Hernia	YES NO		
Diabetes	YES NO	Impaired vision	YES NO
Heart Murmur	YES NO	Impaired hearing	YES NO
Allergies	YES NO	Other: _____	

Specify: _____

Have you had a recent tetanus booster? _____ IF so, when? _____

Are you currently taking any medications? _____ IF so, what? _____

Why? _____

Has the doctor placed any restrictions on your activity? _____

Explain: _____

Signed: _____ Date: _____ Signed: _____ Date: _____

(Athlete)

(Parent)