

# LONG ISLAND ATHLETICS



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## MEDICAL RELEASE FORM

In case of emergency, if family physician cannot be reached, I hereby authorize

\_\_\_\_\_ to be treated by another qualified, licensed  
Player's name Date of birth  
physician who is available.

Family Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_ Street City State Zip

Allergies: \_\_\_\_\_

Medical Plan: \_\_\_\_\_

Name on plan: \_\_\_\_\_

ID #: \_\_\_\_\_

Group #: \_\_\_\_\_

\_\_\_\_\_  
Parent or Guardian (Signature/Relationship)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Playing Season

Emergency Contact Number 1: \_\_\_\_\_

Emergency Contact Number 2: \_\_\_\_\_