LONG ISLAND ATHLETICS

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: _____