BRANCHBURG BASKETBALL ASSOCIATION

MEDICAL RELEASE FORM

Player's Name ______________________________

Address ______________________________

City/State/Zip ______________________________

Birthdate __________ Sex __________ Social Security # __________

Parent/Guardian Phone # __________ (W) __________

Emergency Phone # other than Parent/Guardian:

Name ______________________________ Phone __________

Primary Medical Insurance Company ______________________________

Policy Number ______________________________

Known allergies or other pertinent medical insurance:

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Consent For Medical Treatment (Minor)

As the parent or legal guardian of the above-named player, I hereby give consent to emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve the life, limb or well being of this minor. By signing below I grant the BBA/its agent(s) to act as my surrogate for my child in the area of obtaining medical/dental treatment and I also assume the financial responsibility for any such treatment for my child.

Signature of Parent/Guardian ______________________________

Date __________ WITNESS ______________________________

Address ______________________________

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Phone (h) ______________________________ (w) ______________________________

PLEASE READ ALL INFORMATION CAREFULLY BEFORE SIGNING