

Windsor Senior League Medical Release Form

League I.D. # 207-08-17

To be carried by any Regular Season or Tournament Team Manager together with team roster or eligibility affidavit at all practices/games.

Player Name:	Date of Birth:
--------------	----------------

Parent(s) or Guardian(s) Information:

Father's Name:	Home Phone:	Work Phone:
Mother's Name:	Home Phone:	Work Phone:
Cell phone or pager numbers:		

In an EMERGENCY when parents cannot be reached, please contact:

Name:	Home Phone:	Work Phone:
Name:	Home Phone:	Work Phone:

Player's Physician:	Phone:
Player's Dentist:	Phone:
Hospital Preference:	

Please list any allergies/medical problems, including those requiring maintenance medication (i.e., diabetic, asthma, seizure disorder). The purpose is to ensure that medical personnel have details of any medical concerns which may interfere with or alter treatment.

Allergies:
Medications:
Other Medical Conditions:

Date of Last Tetanus Toxoid Booster:

I/We the parent(s) or legal guardian(s) of the above named candidate for a position on a Senior Little League team, know that participation in baseball may result in serious injuries and protective equipment does not prevent all injuries to players, and do hereby waive, release, absolve, indemnify and agree to hold harmless the local little league (W.I.L.L. or W.A.L.L.), Little League Baseball, Inc., the organizers, sponsors, participants and parents transporting my/our child to and from activities for any claims arising out of any injury to my/our child whether the result of negligence or for any other cause, except to the extent and in the amount covered by accident or liability insurance.

My son/daughter has received a physical examination by a physician and has been found physically capable of participating on a Little League team. I/We hereby give consent to have W.I.L.L. or W.A.L.L. administer basic first aid and an athletic trainer and/or doctor of medicine or dentistry provide my child with medical assistance and/or treatment and agree to be financially responsible for the cost of such assistance and/or treatment.

Parent(s) or Guardian(s) Signatures:	Date:
---	--------------