



**Town of Watertown
Department of Recreation
Medical Release**



Note: To be carried by any Regular Season or Tournament Team Manager together with team roster or eligibility affidavit.

Participant: _____ **Date of Birth:** _____

Address: _____

Phone: _____

Parent or Guardian Authorization:

In case of emergency, if family physician cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel (i.e. EMT, First Responder, and ER Physician)

Family Physician: _____ **Phone:** _____

Address: _____

Hospital Preference: _____

In case of emergency, contact:

Name	Phone	Relationship to participant
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Name	Phone	Relationship to participant
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Please list any allergies/medical problems, including those requiring maintenance medication. (I.e. Diabetic, Asthma, Seizure Disorder)

<u>Medical Diagnosis</u>	<u>Medication</u>	<u>Dosage</u>	<u>Frequency of dosage</u>
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The purpose of the above listed information is to ensure that medical personnel have details of any medical problem, which may interfere with or alter treatment.

Date of last Tetanus Toxoid Booster: _____

Mr./ Mrs./ Ms. _____

Authorized Parent/ Guardian Signature

WARNING: Protective equipment cannot prevent all injuries a participant might receive while participating in Recreational Sports and Activities