

**VALLEY VIEW BULLDOGS  
FOOTBALL MEDICAL RELEASE**

Player: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

League Name: N.A.J.F.L.

Team Name: Valley View Bulldogs

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

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

Address: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

In case of emergency contact:

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Please list any allergies/medical problems including those requiring maintenance medications (i.e. Diabetic, Asthma, and Seizure Disorder)

Medical Diagnosis	Medication	Dosage	Frequency of Dosage

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

Date: \_\_\_\_\_