**CFSA MEDICAL/DENTAL RELEASE FORM 2013**

Player Name:

Parents Name:

Birth Date:

Address:

Phones:

**Allergic to any Medications**?

**Emergency Notifications:**

Name/Phone:

Name/Phone:

Name/Phone:

 **Doctor**

Doctor’s Name: Phone:

Doctor’s Address:

 **Dentist**

Dentist’s Name: Phone:

Dentist’s Address:

 **Insurance**

Insurance Carrier:

Insured Person:

Policy Number:

# **CONSENT FOR TREATMENT**

In case of an emergency, I, , parent or legal guardian of , give my permission to a representative of the Cy-Fair Sports Association to take for medical and/or dental treatment if deemed necessary.

By: Date: