



Player Medical Release



THE UNDERSIGNED:

April 18, 2024

Guardian of Athlete _____

A minor and participating Basketball athlete with LONG ISLAND BASEBALL ASSOCIATION, hereby authorize an officer, coach or agent of the LONG ISLAND BASEBALL ASSOCIATION to transport, as required, the above mentioned athlete for any medical attention.

I hereby give my consent for said athlete to receive any and all medical care necessary to be administrated as prescribed by a duty Licensed Doctor under what ever conditions are necessary to preserve the life, limb, or well being of said athlete.

The hereunder information is to be presented to a Licensed Doctor.

Athlete's Information

| | | | |
|--------------------|----------------------|------------------------|----------------------|
| First Name | <input type="text"/> | Home Address | <input type="text"/> |
| Last Name | <input type="text"/> | Home Address Line 2 | <input type="text"/> |
| Middle Initials | <input type="text"/> | City | <input type="text"/> |
| DOB | <input type="text"/> | State | <input type="text"/> |
| Email | <input type="text"/> | Zipcode | <input type="text"/> |
| Phone | <input type="text"/> | | |

Parent's Information

| | | | |
|-----------------|----------------------|--------------|----------------------|
| Parent Name | <input type="text"/> | Parent Name | <input type="text"/> |
| Parent Phone | <input type="text"/> | Parent Phone | <input type="text"/> |
| Parent Email | <input type="text"/> | Parent Email | <input type="text"/> |

Emergency Contacts

| | | | |
|------------------|----------------------|---------------|----------------------|
| Contact Name | <input type="text"/> | Contact Name | <input type="text"/> |
| Contact Phone | <input type="text"/> | Contact Phone | <input type="text"/> |
| Contact Email | <input type="text"/> | Contact Email | <input type="text"/> |

Medical Information

Insurance
Name

Insurance ID

Know Allergies

Other Medical
Information