MEDICAL RELEASE – CHASE ACADEMY Basketball

I hereby give my permission for any and all medical attention necessary that will be administered to my child[ren], (List NAMES below)

_____date of birth

_____date of birth

_____date of birth

_____date of birth}, in the event of an accident, injury, sickness, etc. under the direction of Lisa Brown or a supervising CHASE parent until I may be contacted.
This release is effective from September 1, 2018, through April 30, 2019.
I also hereby assume the responsibility for payment of such treatment.

MY ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____

HEALTH INSURANCE
COMPANY_____

INSURANCE POLICY NUMBER: _____

OUR PHYSICIAN: _____

PHYSICIAN PHONE: _____

Hospital preference:_____
KNOWN ALLERGIES: _____
OTHER VITAL INFORMATION pertinent to medical care of my child(ren)
_____
_____

In case I cannot be reached, please try to contact:

NAME: _____ PHONE: _____

(PARENT or GUARDIAN) SIGNATURE: _____
PRINTED NAME:_____