FOX VALLEY POP WARNER FOOTBALL, INC.
Medical Release

Player Name: _____Date of Birth: _____

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, E.R. Physician),

Family Physician: _____Phone: _____

Address: _____

Hospital Preference: _____

City _____ State _____ Zip _____

In case of emergency contact:

_____
Name Phone Relationship to Player

_____
Name Phone Relationship to Player

Please list any allergies/medical problems, including that requiring maintenance medication (i.e. Diabetic, Asthma, 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 medical treatment.

Date of last Tetanus Toxoid Booster: _____

Mr. /Mrs. /Ms. _____
Authorized Parent/Guardian Signature