Parent's Medical Release Form

I hereby give permission for any and all medical attention necessary to be administered to my child: _____

I have also authorized alternate persons to be contacted for guidance. I hereby give permission for treatment of my child as may be required and determined by the appropriate health care professional, assigned trainer or coach who is present.

This release remains in effect for the duration of my child's membership with Cypress Triple Thr3at AAU/ Triple Thr3at Sports & Development, Inc. I hereby assume responsibility for payment of such treatment and have attached my child's insurance information.

My name: _____
Phone (H): _____(W): _____(Cell)_____
My home address: _____
City:_____ State: _____Zip:_____

ALTERNATE CONTACT PERSONS: In case I cannot be reached, either of the following is designated an alternative contact person:
Name: _____ Phone: _____
Name: _____ Phone: _____

My insurance carrier / policy number is:_____
My child's physician: _____Physician's Phone: _____
Physician's Address: _____
Known allergies or medical conditions of child: _____
Medications child takes: _____
Parent's name (print): _____
Signature (parent):_____ Date_____