

ST. AUGUSTINE CYO

MEDICAL RELEASE FORM

NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
TELEPHONE _____

Please be advised that _____ is in good physical condition and is capable of participating in the St. Augustine CYO Basketball Program.

SPECIAL ALLERGIES/CONDITIONS _____

PHYSICIAN'S NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
TELEPHONE _____

PHYSICIAN'S SIGNATURE _____ DATE _____

REMARKS _____

PERSONS TO BE NOTIFIED FOR EMERGENCY

NAME _____ PHONE # _____
NAME _____ PHONE # _____

I _____, AUTHORIZED MY CHILD'S COACH TO OBTAIN
PARENT/GUARDIAN
IMMEDIATE MEDICAL ATTENTION FOR MY CHILD REFERENCED ABOVE, IF
NECESSARY.

SIGNATURE _____ DATE _____

*****This form must be completed and returned before a child will be allowed to practice. Please return this form to your coach*****