



**Manchester Essex Little League, Inc.**

P.O. Box 400 Manchester MA 01944

www.essexma.com/mell

**Little League® Baseball and Softball Medical Release Form**

**NOTE:** *To be carried by any Regular Season or Tournament Team Manager together with team roster or eligibility affidavit.*

Player: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

League Name: Manchester-Essex Little League I.D. Number: 2211514.

**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: \_\_\_\_\_ Physician Phone: \_\_\_\_\_

Physician Address: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

In Case of Emergency Contact:

(1) \_\_\_\_\_  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to Player \_\_\_\_\_

(2) \_\_\_\_\_  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to Player \_\_\_\_\_

Please list any allergies/medical problems, including that require 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 treatment.

Date of last Tetanus Toxoid Booster: \_\_\_\_\_

Mr./Mrs./Ms. \_\_\_\_\_  
Authorized Parent/Guardian Signature Date

**WARNING:** Protective equipment cannot prevent all injuries a player might receive while participating in Baseball/Softball.