

Cal Ripken Medical Treatment/Release Form

Player's Last Name

First Name

DOB

Insurance Information

Insurance Provider Name
(ie. BC/BS, Cigna, MVP, Dr. Dynasaur)

Company who you work for
(If a group health plan)

Group ID Number

List names and contact numbers if you can not be reached in case of emergency

Name	Phone	Relationship to player
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Is your child taking any medications or drugs? Yes _____ No _____ If yes, please list below

Please list any ailments or injuries that the league should be aware of in the case of an emergency.

I hereby give my consent and authorization for _____ (player's name) in the event of injury or illness, to be medically treated by a qualified physician and allow such physician to render such medical treatment as the doctor deems necessary under the circumstances including but not limited to first aid treatment, anesthesia, suture of wounds, x-rays and or hospitalization, I hereby waive, release, indemnify and agree to hold harmless the local Babe Ruth organization and its officers and Babe Ruth Baseball, Inc. for any claim arising out of any injury to my child or ward whether the result of negligence or for any other cause, except to the extent of an amount covered by accident, medical or liability insurance policy carried by the local Babe Ruth Baseball organization.

I/We know that participation in baseball may result in serious injuries to my child. Protective equipment does not prevent all injuries to players.

Signature of Parent or Guardian

Date