

JGJC LLC. Camps

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MEDICAL RELEASE FORM

PLAYER: _____

Date of Birth: _____

MEDICAL INFORMATION:

Family Physician: _____ Phone: _____

Physician Address: _____

City _____

Medical Insurance Carrier: _____

Group Policy #: _____ Member #: _____

IN CASE OF AN EMERGENCY, PLEASE CONTACT:

(Primary) Name: _____ Relationship: _____

Phone: _____ Other phone: _____

(Secondary) Name: _____ Relationship: _____

Phone: _____ Other phone: _____

Please list any medical problems, including those requiring maintenance medications (i.e. diabetes; asthma; seizures, allergies, etc). The purpose of this list is to ensure medical personnel have information of any medical issues which may alter, or interfere with, treatment. Medical Diagnosis

Medications

Dosage

Frequency of Dosage

Player Information:

Height: _____

Weight: _____

Position: _____

Club Team: _____