B	Medical Re		
B	NOTE: To be carried by any Regular Team Manager together with team		
Player:		Date of B	irth:
_eague Name:		I.D. Num	ber:
Parent or Guar	rdian Authorization:		
child to be trea	ergency, if family physician can ated by Certified Emergency Pe		
child to be trea Physician)		ersonnel. (i.e. EMT,	First Responder, E
child to be trea Physician) Family Physicia	ated by Certified Emergency Pe	ersonnel. (i.e. EMT, Phone	First Responder, E
child to be trea Physician) Family Physicia Address:	ated by Certified Emergency Pe	ersonnel. (i.e. EMT, Phone	First Responder, E
child to be trea Physician) Family Physicia Address: Hospital Prefer	ated by Certified Emergency Pe	ersonnel. (i.e. EMT, Phone	First Responder, E
child to be trea Physician) Family Physicia Address: Hospital Prefer	ated by Certified Emergency Pe	ersonnel. (i.e. EMT, Phone	First Responder, E

Please list any allergies/medical problems, including those requiring 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

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

Little League Baseball does not limit participation in its activities on the basis of disability, race, color, creed, national origin, gender, sexual preference or religious preference.