MEDICAL RELEASE FORM

This is to certify that my son / daughter, _____, has my permission to participate in the STYSA Regular Season and/or Invitational Tournament. As the parent or legal guardian of the above named player, I request that in my absence, the above named player be admitted to any hospital or medical facility for diagnosis or treatment. I request and authorize physicians, dentists and staff, duly licensed as Doctors of Medicine, or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures, and x-ray treatment of the above named minor. I have not been given a guarantee as to the results of the examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above named person.

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