CONSENT FOR MEDICAL/SURGICAL CARE/EMERGENCY TREATMENT AND CHILD'S MEDICAL INFORMATION

As parent and/or guardian of _____, a minor, I hereby authorize the treatment, by a qualified and licensed medical doctor, in the event of a medical emergency which, in the opinion of the attending physician, may endanger my child's life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me. I further authorize that my child may be transported to a hospital or emergency clinic for treatment. This release is effective for one year from date given below.

FATHER'S NAME_____ MOTHER'S NAME_____

ADDRESS_____

HOME PHONE_____ WORK PHONE_____

MOTHER'S CELL_____ FATHER'S CELL _____

INSURANCE COMPANY_____

POLICY NUMBER_____ **GROUP NUMBER**_____

(PLEASE ATTACH PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD)

In case I cannot be reached, any of the following can act on my behalf:

Coach:_____

Assistant coach :_____

A LEAGUE REPRESENTATIVE WHERE MY CHILD IS PLAYING: YES_____ NO_____

A TOURNAMANT REPRESENTATIVE WHERE MY CHILD IS PLAYING. YES_____ NO_____

MEDICAL INFORMATION

CHILD'S PHYSICIAN AND PHONE NUMBER_____

CHILD'S ALLERGIES, IF ANY:_____

MEDICATIONS CHILD IS CURRENTLY TAKING:_____

MY CHILD WEARS GLASSES_____ **CONTACTS**_____ **BRACES/RETAINER**_____

CHRONIC ILLNESSES_____

ANY OTHER INFORMATION MEDICAL PERSONNEL SHOUD BE MADE AWARE OF:

_____

_____

THIS RELEASE FORM IS COMPLETED AND SIGNED OF MY OWN FREE WILL FOR THE SOLE PURPOSE OF AUTHORIZING MEDICAL TREATEMENT UNDER EMERGENCY CIRCUMSTANCES IN MY ABSENCE.

SIGNATURE (PARENT/GUARDIAN)_____

Subscribed and sworn to before me on this _____ day of _____ 20_____