CONSENT FOR MEDICAL CARE & TREATMENT

In order that your ATHLETE receive prompt and appropriate medical treatment when you cannot be reached to give your consent, please sign this Consent for Medical Care and Treatment and return to your Head Coach. This record will be retained by the team for the current season and accompany the adult in charge at all practices, games, and other team activities.

I hereby give permission for my child to be taken for emergency treatment by her team coach or assistant coach. I also give permission for my child to be transported by ambulance or aid car to an emergency center for treatment. In the event that I cannot be contacted, I further consent to the medical, surgical and hospital care, treatment, and procedures to be performed for my child by a licensed board-certified physician or hospital when deemed an EMERGENCY.

ATHLETE INFORMATION

Name: _____ Date of Birth: _____

Allergies and Drug Reactions: _____

Chronic Illness: _____

Regular Medications: _____

Child's Physician: _____ Phone: ( )_____

Insurance Provider: _____ Group # _____ Policy # _____

Alternative person(s) to contact case of emergency:

Name: _____ Cell Phone: _____ Home Phone: _____

Name: _____ Cell Phone: _____ Home Phone: _____

Parent or Guardian Name: _____

Signature of Parent or Guardian: _____ Date _____