

Palacios Futbol Club

TRANSPORT CONSENT/EMERGENCY FORM

This consent form should be completed by the parent or guardian of any player U18 who will be transported by Palacios Futbol Club, affiliates and/or volunteer parents. No player traveling without a parent or guardian will be allowed to participate without this form being completed and signed by the parent or guardian. The information on this form is considered confidential and will accompany the head coach, _____ of Palacios Futbol Club. This information is necessary should we need to contact you while away.

Permission is granted for:

(Player's Legal name): PLEASE PRINT

I, _____ give permission to _____ to travel to _____ and its surrounding areas with _____ on (dates) _____ through _____.

I AM AWARE THAT MY CHILD WILL BE TRAVELING WITHOUT A LEGAL PARENT OR GUARDIAN, AND ALL INFORMATION PROVIDED ON THIS CONSENT IS TO BE TRUE.

PARENT/GUARDIAN INFORMATION:

Parent/Guardian Name: _____

Address: _____

Emergency Phone #1: _____

Emergency Phone #2: _____

In the unlikely event of an accident occurring, I give my permission for a designated representative of Palacios Futbol Club coach _____ to authorize emergency medical treatment, including the use of anesthetic if deemed necessary. Please provide the information requested below as it may be needed in case of an emergency.

Player Date of Birth: _____

Allergies: _____

Conditions requiring special consideration (medical/physical): _____

Does your player require an: (A) **Epipen** Yes No (B) **Inhaler** Yes No (C) **ANY MEDICATION CURRENTLY TAKING:** (Type of medication and time of administration): _____

SPECIAL DIETARY NEEDS:

TO ANY DOCTOR OR HOSPITAL: I hereby authorize the release of my child's pertinent medical information to the appropriate professional staff. I give permission to the physician or hospital to secure treatment for him/her and to order medications, injections, anesthesia, or surgery for my child, as named above, in case of emergency. The signature below constitutes authorization to perform any necessary treatment for my child.

HEALTH INSURANCE INFORMATION:

Company Name: _____

Policy #: _____

Group #: _____

Parent/Guardian Name: _____

Date: _____

(PLEASE PRINT)

Parent/Guardian Signature: _____