

AUTHORIZATION FOR MEDICAL TREATMENT

Player's name _____ Birth date _____

Address _____

Father's name _____ Phone:(HOME) _____
(WORK) _____

Mother's name _____ Phone:(HOME) _____
(WORK) _____

In case of emergency, when parents cannot be reached, please contact:

Name _____ Phone: _____

Name _____ Phone: _____

Insurance Company: _____

Policy number _____ Group number _____

Physician: _____ Phone: _____

Address: _____

Known allergies: _____

PARENTS APPROVAL

In our absence, I hereby give consent to have an athletic trainer and/or doctor of medicine or dentistry provide my son/daughter medical assistance and/or treatment as directed by any one of the above-named persons, and agree to be responsible financially for the reasonable cost of such assistance and/or treatment.

Signature (parent or guardian) _____ Date _____