

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 \_\_\_\_\_