

CONSENT FOR MEDICAL TREATMENT FORM

ALL TEAMS ARE REQUIRED TO COMPLETE THIS FORM FOR EACH ROSTERED PLAYER. THIS FORM MUST BE CARRIED BY THE TEAM'S MANAGER AT ALL TIMES.

PLAYER'S NAME: _____ PHONE: _____

ADDRESS: _____

CITY, ST, ZIP: _____

FAMILY PHYSICIAN: _____ PHONE: _____

LIST ANY ALLERGIES: _____

LIST ALL MEDICATIONS: _____

BLOOD TYPE: _____ MEDICAL INSURANCE: _____

POLICY or I.D.#: _____ GROUP #: _____

EMERGENCY TELEPHONE NUMBERS:

#	Name	Relationship	Daytime Phone	Evening Phone
1				
2				
3				

In case of illness or accident, I hereby authorize a representative of the _____ team to use his/her judgement in obtaining proper medical care if this player's parent or legal guardian is not available.

PARENT or LEGAL GUARDIAN: _____
(PRINT NAME)

SIGNATURE: _____ DATE: _____

PLEASE TYPE OR PRINT THIS FORM - IT MUST BE LEGIBLE