PARENTAL CONSENT FOR MEDICAL TREATMENT

# Player’s Information

Player’s Name Date of Birth

Home Address Home Phone Number

City, State, Zip

Parental Contact 1st Contact Phone Number

2nd Contact Phone Number

# Caregiver Information:

CELL:

CELL:

The above name caregiver (head coach) shall be authorized to consent for all medical and/or surgical treatment and/or other medical procedures (including administration f anesthesia, blood transfusions, diagnostic tests, etc.), for the above named child, which may be required during my absence. If circumstances permit, I would like to have our doctor consulted in connection with such treatment.

This consent serves as permission for treatment by any hospital.

NOTE: Consent is not required in emergency situations. I agree to pay for all services provided for my child in my absence.

This authorization shall be effective until August 31, 2017.

# Signatures

Parent/Guardian (circle one) Date

Parent/Guardian (circle one) Date

Witness Date

# Family Physician Information:

Name Phone

Address

City, State, Zip

# Insurance Information

Company Name Policy Number

**Medical Information.** Please print and be thorough.

*Chronic or existing medical condition (ex: asthma, seizures, diabetes)*

|  |  |  |
| --- | --- | --- |
| *Known Allergies (circle)*  Anesthetics | Insect stings | Penicillin |
| Aspirin | I.V.P. Dyes | Shellfish |
| Codeine | Morphine | Tetnus Toxoid |
| Demerol  Antibiotics (Please List) | Novocaine |  |
| Other (Please List) |  |  |
| *Current Daily Medications* |  |  |

*Recent Shots and Vaccinations*

Tetanus/Date:

Other/Date:

< If chosen for a Magic team you will be asked to provide a copy of the player’s medical card >