

**Medical Consent Authorization**

Player's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Medical Provider Information:**

Insurance Provider: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Physician: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_  
Physician's Address: \_\_\_\_\_

**In Case of an Emergency Contact:**

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____

**Known Medical Problems and Medications:**

*This information is included to provide information to emergency personnel of medical problems and medications in an emergency situation.*

Existing Medical Problem (Example: Asthma)	Medication Taken (Example: Combivent)	Dosage Taken (Example: 2 puffs)	Dosage Frequency (Example: "Twice Daily")
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Medical Consent Authorization:**

In the event of an injury, accident, illness or other emergency, and if the above stated physician cannot be reached, I authorize my child to be treated by certified emergency personnel such as emergency medical technicians, emergency room physicians and other emergency room personnel such as nurses and laboratory technicians. I agree to accept financial responsibility for the costs related to this medical treatment.

\_\_\_\_\_  
Name of Authorized Parent or Guardian Phone Date Signed