



MEDICAL CONSENT FORM

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Player Information:

First Name _____ M.I. _____ Last _____

Address _____ City _____ Zip _____

Phone _____ Birth Date ____/____/____ Gender M F Age Group U-____

Parent/Guardian Information:

Name _____ Work Phone _____

Address _____ Cell Phone: _____

Parent/Guardian Information:

Name _____ Work Phone _____

Address _____ Cell Phone: _____

Emergency Information:

Person to Contact in case of emergency, other than parent:

Name _____ Work Phone _____

Cell Phone _____ Home Phone _____

Family Physician: _____ Phone _____

List any medical conditions or problems player has, including allergies and medications:

Insurance Information:

Insurance Carrier: _____ Policy Number: _____

Subscriber Name: _____ Subscriber Number: _____

As the parent/legal guardian of the above named child, I hereby give consent that in my absence the above named child be admitted to any hospital or medical facility for diagnosis and/or treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed nurses or technicians, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given guarantee as to the results of examination or treatment. This care may be given under whatever conditions are necessary to preserve life, limb, or well being of my dependant.

Signature of Parent/Guardian _____ Date: _____