## MEDICAL TREATMENT AUTHORIZATION–FALL 2013

Player Name: ______________________________ Birth Date: __________________

Parent/Guardian: ___________________________ Phones: H: _________________________

W: _________________________

C: _________________________

Parent/Guardian: ___________________________ Phones: H: _________________________

W: _________________________

C: _________________________

Emergency Contact: ________________________ Phone: ____________________

Physician Name: ___________________________ Phone: ______________________

Medical Insurance Carrier: _______________________________________________

Known Allergies or Medical Conditions: ____________________________________

_______________________________________________________________________

_______________________________________________________________________

I hereby authorize the manager, coaches, the Emergency Contact, and/or AAD/USSSA program official or representative of the facility where the games are played to act loco parentis as my agent and in my stead to consent to, and any licensed physician and/or licensed medical facility to provide, medical, surgical, or dental examination or treatment deemed necessary and appropriate for my child from Feb 1st, 20__ to November 31st, 20__

Parent/Guardian Signature: ___________________________ Date: _______________