HOLY ANGELS ATHLETICS

CONSENT FOR MEDICAL TREATMENT

PLAYER'S NAME:

ADDRESS:

HOME PHONE:

T-SHIRT SIZE: YOUTH SM MED LG

ADULT SM MED LG

MOTHER'S NAME: EMERGENCY PHONE NO:

FATHER'S NAME: EMERGENCY PHONE NO:

EMAIL ADDRESS:

ADDITIONAL CONTACT PERSON AND PHONE NO:

DOCTOR TO NOTIFY IN EMERGENCY (INCLUDE PHONE NO.):

DENTIST TO NOTIFY IN EMERGENCY (INCLUDE PHONE NO.):

ALLERGIES:

MEDICATIONS:

BRACES/CONTACT LENSES:

AS THE PARENT OR LEGAL GUARDIAN OF THE ABOVE NAMED PLAYER, I HEREBY GIVE MY CONSENT FOR EMERGENCY MEDICAL CARE PRESCRIBED BY A DULY LICENSED DOCTOR OF MEDICINE OR DOCTOR OF DENTISTRY. THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL-BEING OR MY DEPENDENT.

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(SIGNATURE OF PARENT OR GUARDIAN)

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(DATE)