



AUTHORIZATION TO PROVIDE MEDICAL CARE

Coaches- please carry with you to all events

TO ANY HOSPITAL OR MEDICAL PROVIDER: This document constitutes my authorization and consent for you to provide any and all medical and nursing care which you deem necessary or appropriate and in the best interest of my child: Child's Full Name: _____ Date of Birth (Month/Day/Year): _____

I represent to you that I have legal authority to authorize and to consent to such medical care. I further authorize the bearer of this document to execute on my behalf any and all Consent to Treatment forms, including informed consent forms for invasive procedures, which you may require as a condition of treatment. This authorization is effective this _____ day of _____, 20____, and shall remain in effect until I provide written notice of revocation.

My child's personal physician is: Physician's Name: _____

Telephone #: _____ Address: _____

City, State, Zip Code: _____

My child's insurance information is: Insurer/HMO/PPO: _____

Policy #: _____ Group #: _____ Name Of Insured: _____

My Child's ALLERGIES Are: _____

My Child's SIGNIFICANT MEDICAL CONDITIONS and/or RECENT INJURIES are: _____

Date of my child's last tetanus shot: _____

A copy of this Authorization shall have the same force and effect as the original.

Signature: _____ Print Name: _____

Relationship To Child: _____ Address: _____

City, State, Zip: _____ Home Phone: ____/____

Business Phone: ____/____ Emergency contact person (other than parent):

Name/Relationship/Phone #: _____

Subscribed and sworn before me on this _____ day of _____, 20____.

Notary Public: _____ My Commission Expires On: _____