CHANOOKA BRAVES PARTICIPANT MEDICAL EMERGENCY CARD

Participant Name:____

Address:____

City: ____

State: ____________________ Zip:______________________________

Birthdate:____________________

Age as of September 1st ________________________

Home Phone: ____

Primary Emergency Name: ______________________________________

Primary Emergency Phone:______________________________________

Secondary Emergency Name:_____________________________________

Secondary Emergency Phone : ___________________________________

Persons to notify if parents/guardians cannon be reached:

Name:_________________________________

Phone:_________________________________

Name:_________________________________

Phone:_________________________________

Insurance Holders Name: ___________________________

Insurance Co.:____________________________

Insurance ID #:____________________________

Family Doctor:____________________________

Doctor's Phone: ___________________________

Hospital Choice: ___________________________

Current Medications or Special information regarding medical history:____

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CONSENT TO MEDICAL TREATMENT:

If the above named participant needs emergency medical treatment and neither parent nor the family doctor can be reached, consent is hereby granted for such emergency treatment as may be considered necessary in the opinion of the attending physician.

______________________________	____________________________	______________________	___________
Signature of Parent/Guardian	**Print Name**	**Relationship**	**Date**