PAX RIVER RAIDERS YOUTH FOOTBALL LEAGUE

P.O. Box 1422, California, 20619
www.paxriverraiders.org

Emergency Medical Treatment, Consent, and Inforamtion

The following information will be used in the event that a parent/legal guardian in not available. The purpose of this information is to provide a quick reference for medical personnel should the need arise. Please fill out this form completely. If a particular question is not applicable write "none", "n/a", or other appropriate comment otherwise none will be assumed. If additional space is needed, please use the back of this form. All information disclosed here will be treated as confidential. It will be the responsibility of the parent/legal guardian to notify the participants, coach, and league/event officials if any information or updated in any way.

ATHLETE INFORMATION

Athlete's Name:	Nick Name:	Phone: ( )	
Address:	City:	State:	Zip:

PARENT OR GUARDIAN INFORMATION

PARENT/GUARDIAN

Address:	City:	State:	Zip:
Hm Phone: ( )	Daytime Phone: ( )	Email:	
Employer:			

PARENT/GUARDIAN

Address:	City:	State:	Zip:
Hm Phone: ( )	Daytime Phone: ( )	Email:	
Employer:			

FAMILY MEDICAL INSURANCE

Carrier:	Group:	Policy #:	Group #:
Policy Holder Name:			
Family Physician's Name:			
Dr's Address:	City:	State:	Zip:
Phone: ( )	Fax: ( )	Email:	

EMERGENCY MEDICAL INFORMATION

Preferred Hospital (s):

EMERGENCY CONTACT: **Phone: ( )** **Relationship:**

Please list any medical conditions (allergies, asthma, etc.) and medications being taken by the participant named above. Please list any other information you may deem relevant, and helpful to emergency medical personnel: (please note if no information is given and the words "none" or "n/a" is not filled in then, "none" will be assumed.

Allergies:

Medical Conditions:

Other:

*I Hereby my signature grant permission for my child/ward to participate in any and all, Pax River Raiders Youth Football League, program(s), sanctioned event(s), be the official or un-official, including but not limited to athletic, social, and/or fundraising activities. I further hereby consent to any and all health care providers, authorize any first aid, emergency treatment, including but not limited to transportation to and from health care facilities and/or any medical professional to provide treatment, order injections, hospitalize, give anesthesia or perform surgery. I understand that this authorization is given prior to any need for medical care, but given to avoid unnecessary delay in emergency treatment which the attendant and/or medical professional may deem advisable in the exercise of best judgement. I presume a reasonable attempt was made to contact me.

_____ _____ _____

*Print Parent/Legal Guardian Name *Signature Parent/Legal Guardian Date