



THUNDER BASEBALL LEAGUE Consent to Treat/Medical History Form

This is to certify that on this date, I _____, as parent or guardian of _____, (PLAYER), or for myself as an adult participant, give my consent to Thunder Baseball League to obtain medical care from any licensed physician, hospital, or clinic for the above mentioned participant, for any injury that could arise from participation in Thunder Baseball League sanctioned events.

If said participant is covered by any insurance company, please complete the following:

Insurance Company: _____

Policy Number: _____

Parent/Guardian Signature: _____ **Date:** _____

Emergency Contact:

Name: _____ Phone: _____

Address: _____

Physician's Name: _____ Phone: _____

Hospital of Choice: _____

COMPLETION OF MEDICAL HISTORY PORTION IS OPTIONAL

Medical History:

Have you had a recent tetanus booster? Yes No If yes, when? _____

Are you currently taking any medications? Yes No If yes, please list all medications:

Do you have any allergies that we need to be aware of? Yes No If yes, please describe:
