



Western Loudoun Girls Softball League Consent for Treatment

Name of Player: _____ Age: _____

Home Address: _____ City: _____ St: _____

Family Physician: _____ Phone: _____

List of Any Allergies: _____

Required Medication: _____

Name of League: _____ Western Loudoun Girls Softball Team

League Accident Insurance Company: _____

League Accident Insurance Policy No: _____

In case of an accident or illness, I hereby authorize a representative of Western Loudoun Girls Softball League to use his/her judgment in obtaining immediate Medical Care.

DATE: _____ SIGNED: _____
(Parent or Guardian)

Daytime Phone: _____ Home Phone: _____

(Parents will be notified in case of serious illness or injury as quickly as they can be reached, but this will make immediate treatment possible.)



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