

# Watchung Hills Pop Warner Football Association

P.O. Box 4451

Warren, New Jersey 07059

Website: [www.whpw.org](http://www.whpw.org)

## Medical Emergency Consent (MUST BE NOTARIZED)

### PARTICIPANT INFORMATION

Participant's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_  
Town/Zip \_\_\_\_\_

### PARENT/GUARDIAN INFORMATION

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

### EMERGENCY CONTACT (Other than Parents)

1. Name \_\_\_\_\_ Phone # \_\_\_\_\_  
2. Name \_\_\_\_\_ Phone # \_\_\_\_\_

### MEDICAL INFORMATION

Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_  
Participant's Blood type \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_  
Drug Allergies 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
Pediatrician \_\_\_\_\_ Phone # \_\_\_\_\_  
Dentist \_\_\_\_\_ Phone # \_\_\_\_\_  
Other \_\_\_\_\_ Phone # \_\_\_\_\_  
Preferred Hospital \_\_\_\_\_

### POWER OF ATTORNEY FOR EMERGENCY MEDICAL TREATMENT

The parents/lawful guardians of the above named child, minor, have appointed, and by those present appoint the member of the Watchung Hills Pop Warner Football Association, Inc. who is in possession of this document, as my/our true and lawful attorney to act on my/our behalf and stead and to admit my/our minor child to the hospital of their choice and to authorize the administration of such medical treatment as a licensed physician deems necessary and advisable under the circumstances and to make all decisions to administer drugs, operate and all other steps deemed medically necessary, giving my said attorney full power and authority to do everything necessary to be done in the premises as fully as I/We could do if personally present and I/We ratifying and confirming all that my/our said attorney or his substitute shall lawfully do or cause to be done by virtue hereof. I/We hereby authorize the physicians listed above and/or their designated associates or assistants, or their covering physicians, or in the event these persons cannot be contacted, the emergency physician on duty at the hospital of the Power of Attorney's choice, to provide emergency treatment to our child. This consent form and power of attorney is to be effective only after reasonable efforts have been made to contact and obtain my/our specific consent to any emergency treatment. This consent is also to be used in conjunction with the Medical Center's procedure for documented Administrative Authorization.

I/We have read, understand and agree to the terms and conditions of this document.

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_  
Sworn and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_  
Signature of notary \_\_\_\_\_