CHANOOKA BRAVES PARTICIPANT MEDICAL EMERGENCY CARD

Participant Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Birthdate: _____ Age on 9/1/2018: _____

Person(s) to notify if parent/guardian cannot be reached:

Name: _____

Phone: _____

Name: _____

Phone: _____

Mother/Guardian Name: _____

Mother/Guardian Phone No.: _____

Father/Guardian Name: _____

Father/Guardian Phone No.: _____

Insurance Holder's Name: _____

Insurance Company: _____

Policy or Group #: _____

Family Doctor Name: _____

Doctor's Phone No.: _____

Hospital Preference: _____

Current medications and/or information regarding any allergies and medical history: _____

_____

CONSENT TO MEDICAL TREATMENT:

If the above-named participant requires 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**