

Medical History / Emergency Medical Treatment Consent for a Minor Please Return to Head Coach at the 1st PRACTICE!

I hereby authorize the emergency treatment, administration of anesthesia and surgical treatments for my minor child listed below. In the even of any emergency medical situation occurring during my absence or when hospital/medical authorities are unable to contact me, I release from responsibility and liability hospital/medical authorities for performing medical procedures deemed necessary during my absence.

Parent / Guardian's Signature and Date			
Insurance Company		Policy #	

Athlete's Name					
Address					
City		State	MN	ZIP Code	
School		Grade		Date of Birth	/ / 19
Parent / Guardians Name		Work Phone		Other Phone	Pager Cellular
#1		()- -		()- -	
#2		()- -		()- -	
Home Phone	()- -				
Emergency Contact (other than parent)					
Phone Number	()- -	Relationship to Athlete			
Address					
City		State		ZIP Code	
Physician / Clinic					
Phone Number	()- -	Hospital Choice			

Does your child currently or previously suffer from:
Allergies or Allergic Reactions to medications, Asthma, Concussion, Convulsions, Diabetes, Epilepsy, Fainting Spells, Hepatitis A or B, Hernia, Heart Condition, High Blood Pressure, Kidney Problems, Tourette's Syndrome or any other medical condition that may be of concern or life threatening?
No **Yes** **Explain:** _____

Has your child had recent injuries to:
Ankle, Arm, Back, Finger, Head, Knee, Leg, Neck, Shoulder, Spine? Recent Surgeries or other procedures of concern? Has a physician place any restrictions on your child?
No **Yes** **Explain:** _____

Is your child currently taking medication as prescribed by a physician?
No **Yes** **Explain:** _____