

PERMISSION FOR EMERGENCY MEDICAL TREATMENT

PLEASE STAPLE COPY OF FRONT & BACK OF INSURANCE CARD TO THIS FORM.

We _____,
Printed Father's/Guardian's Name Printed Mother's/Guardian's Name

parents/guardians of _____, age _____, hereby authorize any Raiders
Player's Name

Softball coach or parent representative to make decisions as to any required medical treatment for my daughter before, during, or after any tournaments, games and practices while she is a member of Raiders Softball. This includes authorization to have emergency and lifesaving medical procedures administered by appropriate medical personnel. We expect, however, wherever practicable, that an effort will be made to contact one of us in order to receive our specific authorization before any treatment or hospitalization is required.

Father's/Guardian's signature _____ Date _____

Mother's/Guardian's signature _____ Date _____

EMERGENCY INFORMATION

Player _____ Age _____ Date of Birth _____

Father/Guardian _____ Mother/Guardian _____

Home address _____

Phone (Home) _____ Work _____ Cell _____

Additional contact names & numbers _____

Special medical conditions/allergies for medical personnel to know:

Family physician _____ Phone _____

Office name/Location _____

Name of insured _____ Employer _____

Insurance carrier & group # _____

Employer address & phone # _____

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