

HOLY ANGELS ATHLETICS

CONSENT FOR MEDICAL TREATMENT

PLAYER'S NAME:

ADDRESS:

HOME PHONE:

MOTHER'S NAME:

EMERGENCY PHONE NO:

FATHER'S NAME:

EMERGENCY PHONE NO:

ADDITIONAL CONTACT PERSON AND PHONE NO:

DOCTOR TO NOTIFY IN EMERGENCY (INCLUDE PHONE NO.):

DENTIST TO NOTIFY IN EMERGENCY (INCLUDE PHONE NO.):

ALLERGIES:

MEDICATIONS:

BRACES/CONTRACT LENSES:

AS THE PARENT OR LEGAL GUARDIAN OF THE ABOVE NAMED PLAYER, I
HEREBY GIVE MY CONSENT FOR EMERGENCY MEDICAL CARE PRESCRIBED BY A
DULY LICENSED DOCTOR OF MEDICINE OR DOCTOR OF DENTISTRY. THIS CARE MAY
BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE,
LIMB OR WELL-BEING OR MY DEPENDENT.

(SIGNATURE OF PARENT OR GUARDIAN)

(DATE)