



CONSENT FOR TREATMENT

Each Player must complete and have signed

Name of Player _____ Player's Age _____

Home Address _____ City _____ State _____

Family Physician _____ Phone _____

List of Any Allergies _____

Required Medication _____

Name of League _____

League Accident Insurance Company _____

League Accident Insurance Policy No. _____

In case of an accident or illness, I hereby authorize a representative of Babe Ruth League, Inc. to use his/her judgment in obtaining immediate Medical Care.

DATE _____ SIGNED _____

(Parent or Guardian)

Daytime Phone () _____ Home Phone () _____

Cell Phone () _____ Parents Health Ins. Co. _____

Policy # _____

(Parents will be notified in case of serious illness or injury as quickly as they can be reached, but this will make immediate treatment possible.)

Emergency Information Card

Athlete's name _____ Age _____

Address _____

Phone _____ S.S.# _____

Sport _____ Email _____

List two persons to contact in case of emergency:

Parent or guardian's name _____

Address _____

Home phone _____ Work phone _____

Second person's name _____

Address _____

Home phone _____ Work phone _____

Relationship to athlete _____

Insurance co. _____ Policy # _____

Physician's name _____ Phone _____

IMPORTANT

Is your child allergic to any drugs? _____ If so, what? _____

Does your child have any other allergies? (e.g., bee stings, dust) _____

Does your child suffer from _____ asthma, _____ diabetes, or _____ epilepsy?

Is your child on any medication? _____ If so, what? _____

Does your child wear contacts? _____

Is there anything else we should know about your child's health or physical condition? If yes, please explain. _____

Signature

Date