Consent for Treatment

I. ATHLETE INFORMATION

Name _____
Last First Middle

SS#_____ Date of Birth (mm/dd/yyyy) _____

Street Address_____

City_____ State_____Zip _____

Home Phone _____ Cell Phone _____

Medical Problems: □ Asthma □ Diabetes □ Other_____
Contact Lens: □ Yes □ No _____

II. EMERGENCY CONTACT

Name _____

Relationship _____

Street Address_____

City_____ State_____Zip _____

Home Phone _____ Cell Phone _____

III. PARENT INFORMATION

Father/Guardian's name _____

□ *Same address as athlete*

Street Address_____

City_____ State_____Zip _____

Home Phone _____ Cell Phone _____

Mother/Guardian's name _____

□ *Same address as athlete*

Street Address_____

City_____ State_____Zip _____

Home Phone _____ Cell Phone _____

IV. MEDICAL INFORMATION

Insurance Company_____

ID Number _____

Group Number_____

Family Physician _____

Phone Number _____

Dentist Name _____

Phone Number _____

V. AUTHORIZATION

I hereby authorize consent to provide any and all medical services deemed necessary for the welfare of my child in my absence.

_____

Parent Name (please print)

_____

Parent Signature Date