

Mountain View Los Altos Girls Softball Authorization to Treat a Minor

Player Name _____ Birthdate _____

Phone numbers where you can be reached in an emergency – (in priority order):

Name	Number	(circle) Relationship	(circle) Home/Wrk/Cell
_____	_____	Mother/Father	H/W/C
_____	_____	Mother/Father	H/W/C
_____	_____	Mother/Father	H/W/C
_____	_____	Mother/Father	H/W/C
_____	_____	Mother/Father	H/W/C

Non-Parent contact if unable to reach at above numbers:

Name	Number	Relationship	(circle) Home/Wrk/Cell
_____	_____	_____	H/W/C
_____	_____	_____	H/W/C

Family Physician _____ Phone _____ Last Tetanus _____

Last Physical _____ Med. Insurance Co _____ Policy# _____

I (we) do hereby acknowledge that in case of an emergency every effort will be made to contact me (us) at the number(s) listed on this form. The undersigned parent(s) or legal guardian(s) of the player, a minor, do hereby authorize and consent to any x-ray, examination, anesthetic, medical, or surgical diagnosis rendered under general or special supervision of any member of the medical staff and emergency room staff licensed by the Medical Practice Act, or a Dentist licensed under the provisions of the Dental Practice Act and on the staff at any acute general hospital currently licensed by the State Department of Public Health. This Authorization is given pursuant to the provisions of the civil code in my (our) home state. Consent remains in effect until 12/31/10.

Please list any allergies, asthma, heart condition, physical impairment, special medications or other pertinent information needed in an emergency.

Signature of Parent _____ Date _____

Signature of Parent _____ Date _____