Emergency Medical Authorization Form

Player Last Name: ___________________________________ First Name: ____________________________ M.I.: _______

Father/Guardian Name: ____ ❑ Primary Contact

Address: _______________________________________ City: ______________________ State: ________ Zip: _________

Home Phone: _____________________ Cell Phone: _______________________ Work Phone: _____________________

Mother/Guardian Name: ____ ❑ Primary Contact

Address: _______________________________________ City: ______________________ State: ________ Zip: _________

Home Phone: _____________________ Cell Phone: _______________________ Work Phone: _____________________

Alternative person(s) to call in event of emergency, including phone number:

Name: _________________________________ Relationship: __________________ Phone #: _____________________

Name: _________________________________ Relationship: __________________ Phone #: _____________________

Name: _________________________________ Relationship: __________________ Phone #: _____________________

My child is covered by my/our hospitalization and medical/surgical insurance: ❑ YES ❑ NO
If YES, give name of insurance, policy holder name, & insurance phone number:

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Please list facts concerning your child's medical history, including allergies, medications being taken, physical impairments, mental impairments, or any condition to which the league or a physician should be alerted:

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Other information that we may need in case of emergency:

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Lefty Grove Emergency Medical Authorization

This authorization will enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured when parents or guardians cannot be reached.

I am a parent, guardian, or the person with whom the minor lives. If the minor is injured and you cannot reach me, try and reach the other person(s) listed, each of whom hereby are authorized in my absence to consent for treatment to be given to the child.

If, after a reasonable attempt, you cannot reach mee or the persons for permission, I hereby give my consent for any treatment deemed necessary by the physician or dentist listed below, or if the one listed is not available, by another licensed physician or dentist.

Preferred physician: ____

Preferred physician's Phone Number: ____

Preferred dentist: ____

Preferred dentist's Phone Number:____

Other: ____

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This authorization does not cover major surgery unless the opinion of two other licensed physicians or dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

I do hereby release the Lefty Grove Baseball League from responsibility for any and all hospital and medical/surgical expenses arising out of out child's participation in the Lefty Grove Baseball League.

I fully understand that if my/our hospital and medical/surgical insurance will not so cover my child's participation in the Lefty Grove Baseball League, an insurance policy would otherwise be made available by the Lefty Grove Baseball League, Inc.

Signature: ______________________________________ Date: __________________________