



Consent for Treatment

I, _____ (parent/guardian/athlete) being the parent or legal guardian of _____ (athlete), give my consent for emergency medical and surgical treatment of this minor in the event that such treatment becomes necessary. I grant my permission for treatment in a licensed hospital by a licensed physician and the physician's assistants and designees, including such hospital personnel as the physician may deem necessary. I understand that hospital personnel will make reasonable attempts to contact me before initiating treatment. I am aware that the practice of medicine is not an exact science and that no guarantees can be made concerning the results of treatment. The minor named in this consent form may receive all treatment provided according to generally accepted standards of medical practice with the following limitations (if none, write "NONE"): _____

My consent is effective for the following time period: From _____ to 1/01/2010 or: _____.

Signature of Parent or Legal Guardian: _____

Parent / Legal Guardian / Athlete's Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone Number: _____ Identification Number: _____

Medical Insurance Carrier: _____

Address: _____

City: _____ State: _____ Zip: _____

Parent / Legal Guardian / Athlete's Workplace: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone Number: _____

Mother's / Legal Guardian's Workplace Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone Number: _____

Other Contact Person: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone Number: _____ Identification Number: _____

Preferred Hospital & Location _____ Doctor's Name: _____

Medications child is now taking: _____
