

WESTERVILLE YOUTH BASEBALL AND SOFTBALL LEAGUE

EMERGENCY MEDICAL AUTHORIZATION

Player's Name:	Telephone:
Address:	

Purpose – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under coaches' authority when parents or guardians cannot be reached.

PART I OR II MUST BE COMPLETED

PART I – TO GRANT CONSENT

In the event that reasonable attempts to contact me at _____ (phone number) or _____ (phone number) or another parent/guardian at _____ (phone number) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. _____ (preferred physician) or Dr. _____ (preferred dentist), or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to _____ (preferred hospital) or any hospital accessible.

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

Facts concerning the child's medical history including allergies, medications being taken and any physical impairments to which a physician should be alerted: _____

Signature of Parent or Guardian

Date

Address

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

PART II – REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the authorities to take no action or to: _____

Signature of Parent or Guardian

Date

Address