

SPRINGBORO CLEARCREEK BASEBALL ASSOCIATION EMERGENCY MEDICAL AUTHORIZATION

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under Springboro Clearcreek Baseball Association authority, when parent or guardians cannot be reached.

Please use Blue or Black ink.

Participants Name: _____ Sex: M F

Address _____ Zip _____

Home Phone # _____ Grade _____ Date of Birth _____

Father's Name _____ Work Phone _____

Address (if different) _____ Home Phone _____

E-mail address _____ Cell/Pager _____

Mother's Name _____ Work Phone _____

Address (if different) _____ Home Phone _____

E-mail address _____ Cell / Pgr _____

Step Father's Name _____ Work Number _____

Step Mother's Name _____ Work Number _____

Guardian's Name _____ Work Phone _____

(if other than parents)

Address (if different) _____ Home Phone: _____

E-mail address _____ Cell/Pgr _____

Person(s) who may be notified and to whom your child may be released if you cannot be reached.

1. _____ Relationship _____ Phone _____

2. _____ Relationship _____ Phone _____

3. _____ Relationship _____ Phone _____

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

Doctor to be called _____ Phone _____

Dentist to be called _____ Phone _____

Preferred local hospital _____

PART 1-TO GRANT CONSENT

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above named doctor 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 any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Date _____ Signature of Parent / Guardian _____

PART 2- TO REFUSE 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 Springboro Clearcreek Baseball Association to take NO action or to:

Date _____ Signature of Parent /Guardian _____