Medical Authorization

Player Info

Player's Name: _____ Birth Date: _____

Parent/Guardian Name: _____

Address: _____

Home Ph: _____ Cell Ph: _____

Alt./Emrg. Ph: _____ Emrg. Contact Name: _____

E-Mail: _____

Primary Medical Insurance: _____

Plan: _____ Group #: _____

Known Medical Conditions / Allergies: _____

_____

Medications: _____

_____

In case I cannot be reached, I authorize the Miss Scotties Softball, Inc. representative in charge to obtain the medical treatment by a doctor of medicine or dentistry.

I also authorize a trained first aid person or licensed physician to provide immediate and necessary care.

_____

Parent/Guardian Name (Print) Signature Date

_____

Witness Name (Print) Signature Date