MEDICAL TREATMENT AUTHORIZATION

Player Name: _____ Birth Date: _____

Parent/Guardian: _____

Phone: H: _____ W: _____ C: _____

Parent/Guardian: _____

Phone: H: _____ W: _____ C: _____

Emergency Contact(s): _____ Emergency Phone: _____

_____ Emergency Phone: _____

Physician Name: _____ Physician Phone: _____

Hospital preference: _____

Medical Insurance Carrier: _____

Known Allergies or Medical Conditions: _____

_____

I hereby authorize the coaches, the Emergency Contact(s), and/or other AYSO officials to act in loco parentis as my agent and in my stead to consent to, and any licensed physician and/or licensed medical facility to provide medical, surgical, or dental examination or treatment deemed necessary and appropriate for my child during the period 1 August of this year through 31 July of next year. I also approve the coach/ assistant coach to give my child sunscreen to be self-administered.

Parent/Guardian Signature: _____ **Date:** _____