Louisville Soccer Club

Consent for Medical Treatment

Print child's first, middle and last name:____

1. Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under Louisville Soccer Club authority, when parents or guardians cannot be reached.

Part 1A or 1B Must be completed

1A. To grant Consent

In the event reasonable attempts to contact me at ____
(phone number)

or ___________________________________at____
(other parent or guardian) (phone number)

have been unsuccessful, I hereby give my consent for: (1), the administration of any treatment deemed necessary by:

Dr. _____________________________________or, Dr.______________________________________
(preferred physician) (preferred dentist)

Or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist: and

To ____or, any hospital reasonably accessible.
(preferred hospital)

This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists, concerning 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 physical impairments to which a physician should be alerted:

Date:__________________________________ Signature of Parent/Guardian:__________________________________

Printed Name of Parent/Guardian:______________________________

Do not complete part 1B if you have completed part 1A

1B. 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 medical treatment, I wish the Louisville Soccer Club authorities to take no action or to:

Date:____________________________Signature of Parent/Guardian: _____________________________________

Printed Name of Parent/Guardian:_____________________________________