

## **AUTHORIZATION TO TREAT A MINOR**



This consent shall remain effective until: December 31, 20\_\_
This form must be kept with Manager / Coach

at ALL PRACTICES and GAMES

Player Name:		Date of Birth:	
Address:			
League Name: RENO FASTP	ITCH SOFTBALL LEAGUE	≣	
Family Physician:		Phone:	
Hospital Preference:			
In case of emergency conta	act:		
Name	Phone		Relationship to Player
Name	Phone		Relationship to Player
Please list any allergies / medimedication(s). (i.e., Diabetic, A	•	, including thos	se requiring maintenance
Medical Diagnosis	Medication	Dosage	Frequency of Dosage
The purpose of the above is details of any medical probabilities.  I (we) the undersigned parent(s) or a minor, do hereby authorize and rendered under the general or specificensed under the provisions of the Practice Act and of the staff of any State Department of Public Health. diagnosis, treatment, or hospital can which the aforementioned physician that effort shall be made to contact above treatment will not be withheld	legal guardian of, consent to any x-ray examinated and supervision of any member of the Medicine Practice Act or Dentification and the supervision of the this authorized the sunderstood that this authorized by the sundersigned prior to render the undersigned prior to rendersigned prior	cion, anesthetic, roof the medical statist licensed under a current license to thorization is give to provide authorization may deen ing treatment to	medical, or surgical diagnosis aff and emergency room staff the provisions of the Dental to operate a hospital from the en in advance of any specificity and power to render care in advisable. It is understood

THIS FORM MUST BE COMPETED AND SIGNED PRIOR TO CHILD PARTICIPATION

WARNING: Protective equipment cannot prevent all injuries a player might receive while participating in Softball

Signature of Father, Mother or Legal Guardian