SPRINGFIELD YOUTH CLUB VOLLEYBALL

AUTHORIZATION FOR EMERGENCY TREATMENT

I, _____, authorize any physician, (Parent or Guardian) in the case of an emergency, to render medical treatment, which in his/her judgment may be deemed necessary in the care of _____. (Player)

PLAYER'S MEDICAL INFORMATION

Name of Physician _____

Physician's telephone number _____

Allergies _____

Current medications _____

MEDICAL INSURANCE INFORMATION

Insurance Company _____

Identification/Policy No. _____

Insured's Name _____

Insured's Place of Employment _____

Insured's Telephone No. _____

NOTE: Head Coaches or Team Parents are responsible for maintaining this form and making it available to the hospital medical personnel.

Signature _____ Date _____

(Parent or Guardian)

Telephone (H) _____ (W) _____

Cellular (Father) _____ (Mother) _____