By signing below, I give my child permission to participate in the Kaukauna Youth Baseball Travel program, and should injury occur, I authorize you to obtain emergency medical and/or dental care. I will assume financial responsibility for the bills incurred as a result of this care. I further acknowledge the inherent risks of this sport, and agree to hold Kaukauna Youth Baseball and all Coaches and Board Members harmless in the event an injury would occur. I further certify by signing below that to the best of my knowledge, the player named hereon is physically fit to engage in this activity and that the information I'm providing is true and correct.

Medical Treatment Consent Form
CHILD'S NAME: _____ DATE OF BIRTH:_____
ADDRESS_____
FATHER'S NAME: _____ EMPLOYED AT:_____
HOME PHONE: _____ BUSINESS PHONE:_____
MOTHER'S NAME: _____ EMPLOYED AT:_____
HOME PHONE: _____ BUSINESS PHONE: _____
IF PARENTS ARE NOT AVAILABLE IN AN EMERGENCY, CONTACT:
Name: _____ Phone Number: _____
Address: _____
Relationship to Child: _____
CHILD'S DOCTOR: _____ FAMILY DOCTOR: _____
CHILD IS ALLERGIC TO: _____
MEDICAL INFORMATION (including last Tetanus Shot, major illness):
_____
INSURANCE COMPANY & POLICY NUMBERS _____
RESPONSIBLE PARTY: _____

Medical Treatment Consent for Minors

Dear Parent or Guardian:
This card should be presented to the attending physician if your child is in need of medical treatment during your absence. Have each or your minor children (through age 18) carry a card with them or have it available when you are absent. This card will prevent delay of treatment for your child because of lack of proper authorization. Individual hospitals, or physician offices may require additional authorization.

I hereby authorize the treatment, administration of anesthesia and surgical treatment(s) for my minor child:_____ in the event of a medical situation occurring during my absence or when the hospital or physican(s) are unable to contact me. This authorization extends to any hospital or physician office and both physician and nursing personnel within the hospitals or physician office(s) as well as any physican(s) where treatment is rendered in the hospital or physician office, medical authorities and physicians for performing medical procedures acting on the authority of this medical treatment consent form which are deemed necessary to my minor child.

_____
Signature of Parent or Legal Guardian Date

_____
Witness

PS1151 Rev. 5/97 ThedaCare Print Center