



MEDICAL AND CONTACT INFORMATION

Authorization for Treatment of a Minor

In the event of an emergency medical situation relating to my minor child as listed below, and in the event that I am unavailable, I hereby give my consent to St. Alexius Medical Center or any other medical hospitals to administer whatever emergency medical care deemed appropriate by that medical staff until I can be contacted.

Parent/Guardian signature _____ Date _____

Player's Name _____ Birth date _____

Address _____ City/Zip _____

Medical problems _____

Medications/Allergies _____

Date of last tetanus shot _____

Family Doctor _____ Phone _____

Father's name _____ Phone _____

Father's Cell _____ Pager _____

Mother's name _____ Phone _____

Mother's Cell _____ Pager _____