HOPEDALE YOUTH BASEBALL ASSOCIATION
P.O. Box 174
Hopedale, MA 01747

MEDICAL INFORMATION AND EMERGENCY TREATMENT CONSENT FORM

You must complete, sign and return this form to your child's participation in any practice or game.

A. MEDICAL INFORMATION

Player's Name: _____Parent/Guardian Name(s): _____
Player's Date of Birth: _____/_____/_____ Phone: _____
Address: _____
Insurance Co.: _____Policy/ID #:_____
Physician's Name and Phone Number:_____

List Two Persons To Contact In Case of Emergency:

1) Name:_____ Home Phone:_____
Work Phone: _____ Cell Phone:_____
Relationship to Player: _____

2) Name: _____ Home Phone:_____
Work Phone: _____ Cell Phone:_____
Relationship to Player: _____

Important:

Is your child allergic to any drugs? _____ If so,what?_____
Does your child have any allergies? (e.g. bee stings, dust, medication)_____
Is your child taking any medication? If so, what? _____
Does your child wear contacts? _____
Is there anything else we should know about your child's health or physical condition?
_____
_____
_____
_____
_____
_____
_____

B. EMERGENCY TREATMENT CONSENT

I/We grant permission, in my absence, to the coaches of my child's assigned team, or officials of the Hopedale Youth Baseball Association, to seek medical treatment for my child and further grant permission to any qualified physician or health care facility to provide emergency treatment in the event of any injury or illness requiring treatment as a result of participation in any activity of the Hopedale Youth Baseball Association.

_____ _____/_____/_____
Parent/Guardian Signature Date