EMERGENCY MEDICAL AUTHORIZATION
SOUTH RANGE LITTLE RAIDERS

_____

Child's Name

_____

Address

_____

Home or Cell Phone

PURPOSE: *To enable parents and guardians to authorize the provision of emergency treatment for players and cheerleaders who become ill or injured while under the league authority, when parents or guardians cannot be reached.*

PART I OR II MUST BE COMPLETED
PART I: GRANT CONSENT

In the event reasonable attempts to contact me/us:

Home Phone _____

Mother's Work/Cell Phone _____

Father's Work/Cell Phone _____

Neighbor or Alternate Phone _____

Caregiver or Alternate Phone _____

If all of these attempts have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by:

Preferred Doctor _____Phone _____

Preferred Dentist _____Phone _____

Preferred Hospital _____Phone _____

In the event the designated preferred practitioner is not available, then treatment by another licensed physician or dentist is granted. In the event that the preferred hospital is not accessible, then the nearest accessible hospital is preferred. This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery are obtained prior to the performance of such surgery. Facts concerning the child's medical history including allergies, medications being taken and any physical impairments to which a physician should be alerted to:

_____

_____

_____ _____

Date Signature of Parent or Guardian

DO NOT COMPLETE PART I IF YOU COMPLETE PART II
PART II: REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the league authorities to take no action or to:

_____

_____

_____ _____

Date Signature of Parent or Guardian