

EMERGENCY MEDICAL AUTHORIZATION
Westerville WarCats Fastpitch Softball, LLC

Purpose of this Document: To enable parents/guardians to authorize the provision of emergency treatment for children who become ill or injured while under coaches authority when parents/guardians cannot be reached.

Player's name _____
date

Address *City, State* *ZIP*

NOTE: PART I OR PART II MUST BE COMPLETED

PART I – GRANT OF CONSENT

In the event reasonable attempts to contact:

1. *parent/guardian name* _____ & *phone #* _____
2. *other parent/guardian name* _____ & *phone #* _____
3. *other emergency contact name* _____ & *phone #* _____

have been unsuccessful, I hereby give my consent for:

1. The administration of any treatment deemed necessary by:
preferred physician, Dr. _____ & *phone #* _____ OR
preferred dentist, Dr. _____ & *phone #* _____ OR
in the event the designated practitioner is not available, by another licensed physician or dentist, and
2. The transfer of the child to _____ or any hospital accessible.

This authorization DOES NOT cover major surgery unless the medical opinions of two other licensed physician or dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the above named child's medical history including allergies, medications being taken, and any physical impairment to which a physician should be alerted are:

Signature of parent/guardian *Date*

PART II – REFUSAL OF CONSENT

Note: Do not complete this section if you completed Part I

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 authorities to take no action or to:

Signature of parent/guardian *Date*