



# Consent for Medical Treatment Form



Name of Player \_\_\_\_\_ Player's Age \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State NY

Family Physician \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Do you have any allergies? Yes \_\_\_ No \_\_\_

List all allergies: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Required Medication (s) \_\_\_\_\_

Name of League: POUGHKEEPSIE BABE RUTH BASEBALL LEAGUE

League Accident Insurance Company \_\_\_\_\_ K & K Insurance Group

League Accident Insurance Policy Number \_\_\_\_\_ SPP0003695300

In case of accident or illness, I hereby authorize a representative of Babe Ruth League, Inc. to use his /her judgment in obtaining immediate Medical Care.

Date: \_\_\_\_\_ Signed: \_\_\_\_\_

Daytime Phone ( ) \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

\_\_\_\_\_

Parents will be notified in case of serious illness or injury as quickly as possible but this will make immediate care and treatment possible.