AUTHORIZATION TO OBTAIN EMERGENCY MEDICAL CARE

Signing this form gives legal permission to medical personnel to treat your child in case of illness or injury. The law requires permission from a child's natural parent or legal guardian before treatment if illness or injury that is not life threatening.

I give my permission for any emergency medical care or treatment by a physician, surgeon, hospital, or medical care facility that may be required, including transportation and accept responsibility for the cost.

Name: _____ **Date of Birth:** _____
Please print

Allergies: _____

Medical Conditions: _____

_____

Current Medications: _____

_____

Insurance Name: _____

Policy #_____ Group #_____

Policyholder: _____

I hereby grant permission to authorize emergency medical treatment during the period of participation in the **7 on 7 State Championship**.

Player Signature: _____

Parent/Legal Guardian Signature: _____