



North Penn Baseball Association

EMERGENCY TREATMENT AUTHORIZATION FORM

To Whom It May Concern:

As a parent and/or guardian of _____, a minor, I hereby authorize the treatment by a qualified and licensed medical doctor in the event of a medical emergency which, in the opinion of the attending physician, may endanger my child's life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Name of Parent/Guardian _____

Address _____

City _____ State _____ Zip _____

Daytime Phone: () _____ Alt. Phone: () _____

Evening Phone: () _____

Family Physician: _____ Phone: _____

Insurance Coverage Information

Insurance Provider : _____ Telephone: _____

Employer : _____ Telephone: _____

Insurance Co. : _____ Policy No. : _____

The dates during which release is granted are from the beginning of the North Penn Baseball practice season through the end of the season, one year from the date below.

Indicate specific medical allergies, chronic illnesses, or other medical conditions coaches and medical personnel should be aware of:

Other person to contact in case of emergency: _____

Relationship to child: _____

Daytime Phone: () _____

Evening Phone: () _____

This release form is completed and signed of my own free will for the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Signature: _____ Witnessed by: _____

Date: _____