2027 Spring Football League

EMERGENCY MEDICAL TREATMENT, CONSENT AND INFORMATION

The following information will be used in the event that a parent / legal guardian is not available. The purpose of this information is to provide a quick reference for medical personnel should the need arise. Please fill out this form completely. If a particular question is not applicable write "none", n/a, or other appropriate comment otherwise none will be assumed. If additional space is needed, please use the back of this form. All information disclosed here will be treated as confidential. It will be the responsibility of the parent/legal guardian to notify the participants coach and league/event officials if any information needs to be added, deleted, changed, or updated in any way.

ATHLETE INFORMATION			
Athlete's Name:	**DATE OF BIRTH**:	**Phone: ( )**	
Address:	**City:**	**State:**	**Zip:**

PARENT OR GUARDIAN INFORMATION			
Name:			
Address:	City:	State:	Zip:
Hm Phone: ( )	Daytime Phone: ( )	Email:	

FAMILY MEDICAL INSURANCE			
Carrier:		**Group:**	
Policy #:		**Group #:**	
Policy Holder Name:			
Family Physician's Name:			
Dr's Address:	City:	State:	Zip:
Phone: ( )	Fax: ( )	Email:	

EMERGENCY MEDICAL INFORMATION		
Preferred Hospital(s):		
Emergency Contact 1 :	**Phone: ( )**	**Relationship:**
Emergency Contact 2 :	**Phone: ( )**	**Relationship:**
Please list any medical conditions (allergies, asthma, etc.) And medications being taken by the participant named above. Please list any other information you may deem relevant, and helpful to emergency medical personnel: (please note if no information is given and the words "none" or "n/a" is not filled in then, "none" will be assumed.		
Allergies:		
Medical Conditions:		

I Hereby my signature grant permission for my child/ward to participate in any and all, **Spring Football League and/or Local Affiliate(s)**, program(s) sanctioned event(s), be they official or un-official, including but not limited to, athletic, social and/or fundraising activities. I further hereby consent to any and all health care providers, authorize any first aid, emergency treatment, including but not limited to transportation to and from health care facilities and/or any medical professional to provide treatment, order injections, hospitalize, give anesthesia or perform surgery which is deemed advisable by and to be rendered under the general or special supervision of any physician and/or surgeon. I understand that this authorization is given prior to any need for medical care, but given to avoid unnecessary delay in emergency treatment which the attendant and/or medical professional may deem advisable in the exercise of best judgment. I presume a reasonable attempt was made to contact me.

_____ _____ _____/_____/_____

Print Name **Signature** **Date**