

Registration form must be properly signed to be accepted.

St. John Athletic Boosters

Emergency Medical Information

Player's Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Emergency Phone: _____

Medical Information: _____

Insurance Co. _____ Policy Number: _____

PART I – TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called.

Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

Local Hospital: _____

In the event reasonable attempts to contact me have been unsuccessful I hereby give consent for (1) the administration of any treatment deemed necessary by the above named doctor or in the event the designated preferred practitioner is not available, by another licensed doctor or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Date: _____ Signature of Parent/Guardian: _____

PART II – NOT TO GRANT CONSENT

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 following action to take place: _____

Date: _____ Signature of Parent/Guardian: _____

THIS MEDICAL FORM MUST BE PROPERLY FILLED IN AND SIGNED TO BE REGISTERED.