Topeka Queens Softball

Emergency Medical Authorization

Players Name: ____

Parent or Legal Guardian: ________________________________
Address: ____
City/State/Zip: ____
Phone/Cell: ____

Team Name: ____
Head Coach: ____

In the event reasonable attempts have been made to contact Me/Us ______________ are unsuccessful; I (we) said Parent/Legal Guardian authorize any hospital, clinic or licensed physician to treat my/our child and administer any X-Ray, examination, anesthetic or surgical diagnosis rendered under general or special supervision of any member of the medical staff of the hospital, clinic or office.

Preferred Physical: ________________ Phone number: ________________

Preferred Dentist: ________________ Phone number: ________________

Preferred Hospital: ____________________________

In the event the designated preferred practitioner is not available, we authorize in advance another licensed physician or dentist the authority and power to render care in his/her best judgment and the transfer of the child to any hospital reasonably accessible. It is also understood that every effort shall be made to contact the parent/legal guardian prior to rendering treatment to the patient, but that treatment will not be withheld if the parent/guardian cannot be contacted. Permission is also granted for the team's athletic trainer or coach to provide emergency treatment to my/our child(ren) prior to his/her admission to any medical facility.

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Signature of Parent/Legal Guardian Date

List of restrictions/Physical impairments:

____

List of special medications taken by child:

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