EMERGENCY MEDICAL AUTHORIZATION FORM

Participant Name: _____
Address: _____
_____
Date of Birth: _____
Telephone: _____
Email (optional) _____

Purpose – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under Little League authority, when parents or guardians cannot be reached.

Residential Parent or Guardian
Mother's Name: _____ Contact Phone: _____
Father's Name: _____ Contact Phone: _____
Other's Name: _____ Contact Phone: _____

Name of Relative or Childcare Provider: _____
Address _____
Relationship _____ Contact Phone: _____

PART I OR II MUST BE COMPLETED

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 _____ Phone: _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician 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 other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.
Facts concerning the child's medical history including allergies, medications being taken, and any physical impairment to which a physician should be alerted:
_____
_____
_____

Date: _____ Signature of Parent/Guardian _____
Address: _____
_____

PART II – REFUSAL TO 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 school authorities to take the following action:

_____
_____
_____

Date _____ Signature of Parent/Guardian: _____
Address: _____
_____