

BEAR CREEK JUNIOR BASEBALL

AUTHORIZATION TO OBTAIN MEDICAL ATTENTION  
(for coach to keep on file)

PLAYERS NAME \_\_\_\_\_

PLAYERS ADDRESS \_\_\_\_\_

\_\_\_\_\_

PLAYERS PHONE NUMBER \_\_\_\_\_

PLAYERS DATE OF BIRTH \_\_\_\_\_

PLAYERS MOTHER \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

PLAYERS FATHER \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

IN CASE OF EMERGENCY, NOTIFY:

\_\_\_\_\_  
\_\_\_\_\_

KNOWN MEDICAL CONDITIONS – INCLUDE ALLERGIES

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HOSPITAL PREFERENCE \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

FAMILY DENTIST \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

I hereby grant permission to managing personnel to authorize and obtain medical and/or dental care treatment from any licensed physician, hospital or medical facility should my child become ill or injured while participating in league activities away from home or at any other times when neither parent (or legal guardian(s)) are available to authorize emergency treatment.

DATE \_\_\_\_\_

SIGNED BY PARENT OR LEGAL GUARDIAN \_\_\_\_\_