

CENTRAL SPRINGFIELD LITTLE LEAGUE

Medical Information and Emergency Authorization

PLAYER INFORMATION	
Full Name:	Last First MI
MEDICAL INFORMATION	
Allergies:	
Medication (Routine):	
Special Instructions (If Any):	
EMERGENCY INFORMATION	
Contact Name (Relation):	Contact Phone:
Physician Name	Physician's Phone
Insurance Provider	Policy/Identification No.
Insurance Subscriber's Name	Subscriber's Place of Work
EMERGENCY AUTHORIZATION	
<p>Part A: I hereby authorize any physician member of the Department of Emergency Medicine of Commonwealth Hospital, The Fairfax Hospital, Access, or the Mount Vernon Hospital and/or any member of the medical staffs of the listed hospitals requested by the Department of Emergency Medicine physician to render medical treatment, which in his/her judgment may be deemed necessary in the care of _____ .</p> <p>(Players Name)</p> <p>Part B: The manager and/or coach have my permission to call my physician or another in an emergency when my physician or I cannot be contacted. By law, a parent cannot consent in advance to any and all manner of emergency care, the attending physician may defer treatment pending a parent's permission to administer such care.</p>	
_____	_____
Parent/Guardian Signature	Date