

Broken Arrow Girls Softball League – Medical Treatment Authorization Form

This form grants temporary authority to a designated adult to provide and arrange for medical care for a minor in the event of an emergency, where the minor is not accompanied by either parents or legal guardians, and it may not be feasible, or practical to contact them. This form will be retained by the designated adult.

Minor:

Full Legal Name: _____

Home Address: _____

City: _____ State: _____ Date of Birth: _____

Information for Medical Treatment:

Physician's Name: _____

Location of Practice: _____

Physician's Phone Number: _____

Medical Insurer/Health Plan: _____

Policy Number: _____

Allergies to Medications: _____

Allergies – Other: _____

Please note ALL conditions for which the minor is currently receiving treatment (Use the back of form if needed):

Authorization for Emergency Care of Minor:

I, the undersigned parent/legal guardian of the minor child listed above, do hereby authorize any x-ray examination, anesthetic, dental, medical or surgical diagnosis or treatment by any state licensed physician or dentist and hospital service that may be rendered to said minor under the general specific or a special consent of the manager or coaches of the Broken Arrow Girls Softball League (BAGSL) team to which the minor is assigned or has voluntarily joined. The diagnosis or treatment may be rendered at the office of the physician or dentist or at a state licensed hospital. I authorize the physician or dentist to call in any necessary consultants at their discretion. It is understood that this consent is given in advance of specific diagnosis or treatment being required and is given to encourage team managers and coaches, physicians and dentists to exercise their best judgment, in the parents of guardians absence, as to the requirements of such diagnosis or medical or dental or surgical treatment in the best interest of the health and welfare of the minor child. This authorization and consent shall remain effective until December 31 of the signed year unless sooner revoked in writing and delivered to the BAGSL at PO Box 2112, Broken Arrow, OK 74013.

Parent/Legal Guardian Signature: _____

Print Name: _____

Parent/Legal Guardian Phone: _____ Date: _____

Emergency Contact: _____

Relationship: _____ Phone: _____