MEDICAL TREATMENT AUTHORIZATION

Player Name: ___________________________________ Birth date: _________________________

Parent/Guardian: ________________________ Phones: H: ______________ W: _____________

C: _________________________

Parent/Guardian: ________________________ Phones: H: _______________W: _____________

C: _____________________

Emergency Contact: _________________________Emergency Phone: _____________________

Physician Name: ____________________________Physician Phone: ________________________

Medical Insurance Carrier: ____

Known Allergies or Medical Conditions: ____

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I hereby authorize the coaches, the Emergency Contact, and/or other AYSO officials to act in loco parentis as my agent and in my stead to consent to, and any licensed physician and/or licensed medical facility to provide, medical, surgical, or dental examination or treatment deemed necessary and appropriate for my child during the period 1 August of this year through 31 July of next year. *I also approve the coach/assistant coach to give my child sunscreen to be self administered.*

Parent/Guardian Signature: ______________________________________ Date: _____________