MEDICAL CONSENT TO TREAT
Form

Please Print

Players Name:			
Address:		Phone:	
D.O.B.	Age:	Weight:	Sex:
Physician Choice (1)		(2)	
Parent or Legal Guardian:		Phone:	
Other person to contact:		Phone:	

General Medical Health/History: _____

Prescription and non-prescription medicine currently taking :(If none then state none)

_____

List all allergies :(food, medicine, latex, bee stings, etc.)(If none then state none)

_____

Any other special needs or concerns :(If none then state none)

_____

As parent, legal guardian or other blood relative of above named minor I herewith authorize any representative of Andrews County Youth Recreation Center to seek or obtain medical treatment in case of emergency or accident. I also grant permission for any medical treatment or action that medical personnel deem necessary after a reasonable effort has been made to reach me.

Authorized Signature

_____

Signature Relationship Date