

# CHANOOKA BRAVES PARTICIPANT MEDICAL EMERGENCY CARD

Participant Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Age as of September 1, 2011 \_\_\_\_\_

Home Phone: \_\_\_\_\_

Primary Emergency Name: \_\_\_\_\_

Primary Emergency Phone: \_\_\_\_\_

Secondary Emergency Name: \_\_\_\_\_

Secondary Emergency Phone : \_\_\_\_\_

Current Medications or Special information regarding medical history: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## CONSENT TO MEDICAL TREATMENT:

If the above named participant needs emergency medical treatment and neither parent nor the family doctor can be reached, consent is hereby granted for such emergency treatment as may be considered necessary in the opinion of the attending physician.

\_\_\_\_\_

Signature of Parent/Guardian

\_\_\_\_\_

Print Name

\_\_\_\_\_

Relationship

\_\_\_\_\_

Date

Persons to notify if parents/guardians cannot be reached:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Insurance Holders Name: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_

Family Doctor: \_\_\_\_\_

Doctor's Phone: \_\_\_\_\_

Hospital Choice: \_\_\_\_\_