



AMERICAN YOUTH FOOTBALL

Emergency Medical Treatment, Consent and Information



ASSOCIATION NAME - _____

_____ (childs name) Has My Permission To Participate In Any And All, _____ (association name) And, American Youth Football, Inc / American Youth Cheer DBA Program(S) Sanctioned Event(S), Be They Official Or Un Official, Including But Not Limited To, Athletic, Social And/Or Fundraising Activities. I Further Hereby Authorize Any First Aid, Emergency Treatment, Including But Not Limited To Transportation To And From Health Care Facilities And/Or Any Licensed Physician To Provide Treatment, Order Injections, Hospitalize, Give Anesthesia Or Perform Surgery. I Understand That This Authorization Is Given Prior To Any Need For Medical Care, But Given To Avoid Unnecessary Delay In Emergency Treatment Which The Physician May Deem Advisable In The Exercise Of Best Judgment. I Presume A Reasonable Attempt Was Made To Contact Me.

EMERGENCY MEDICAL INFORMATION

The Following Information Will Be Used In The Event That A Parent / Legal Guardian Is Not Available. The Purpose Of This Information Is To Provide A Quick Reference For Medical Personnel Should The Need Arise. Please Fill Out This Form Completely. If A Particular Question Is Not Applicable Write "None", N/A, Or Other Appropriate Comment otherwise NONE will be assumed. If Additional Space Is Needed, Please Use The Back Of This Form. All Information Disclosed Here Will Be Treated As Confidential. It Will Be The Responsibility Of The Parent/Legal Guardian To Notify The Participants Coach And League/Event Officials If Any Information Needs To Be Added, Deleted, Changed, Or Updated In Any Way. Please Keep A Copy For Your Records.

Participants Name: _____ **Nick Name** _____ **Hm Phone:** _____

Street Address: _____ **City / Town:** _____ **State:** _____ **Zip:** _____

Father's Name: _____ **Email:** _____

Street Address: _____ **City / Town:** _____ **State:** _____ **Zip:** _____

Employer: _____ **Hm Phone:** _____ **Wk Phone:** _____ **Cell :** _____

Mother's Name: _____ **Email:** _____

Street Address: _____ **City / Town:** _____ **State:** _____ **Zip:** _____

Employer: _____ **Hm Phone:** _____ **Wk Phone:** _____ **Cell :** _____

Family Medical Insurance:

Family Physician:

Carrier: _____

Name: _____

Group: _____

Address: _____

Policy #: _____

Phone Number: _____

Group #: _____

Alt Phone: _____

ID#: _____

Preferred Hospital: (1) _____ (2) _____

EMERGENCY CONTACTS: (MUST HAVE AT LEAST TWO CONTACTS)

Name: _____ **Phone #:** _____ **Relationship to Player** _____

Name: _____ **Phone #:** _____ **Relationship to Player** _____

Please List Any Medical Conditions (Allergies, Asthma, Etc.) And Medications Being Taken By The Participant Named Above. Please List Any Other Information You May Deem Relevant, And Helpful To Emergency Medical Personnel: (Please Note If No Information Is Given And The Words "None" Or "N/A" Is Not Filled In Then, "None" Will Be Assumed.

I HAVE READ, REVIEWED FOR ACCURACY, UNDERSTOOD, ACCEPTED AND AGREED TO THE ABOVE:

***Print Parent/Legal Guardian Name**

***Signature Parent/Legal Guardian**

***Date**