

**LONGMEADOW BASEBALL ASSOCIATION  
CONSENT FOR MEDICAL TREATMENT**

As parent of the below mentioned player, I hereby give my consent for emergency medical care prescribed by a duly licensed physician or dentist. This care may be given under whatever conditions are necessary to preserve life, limb or well being of my dependent. You have my permission to take whatever action is deemed necessary for the health and welfare of my child.

PLAYER NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

TELEPHONE # \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_

NAME (PLEASE PRINT) \_\_\_\_\_

Date \_\_\_\_\_

ADDRESS (IF DIFFERENT) \_\_\_\_\_

HOME PHONE # \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

BUS. PHONE # \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

DENTIST \_\_\_\_\_

HIGHLY ALLERGIC TO \_\_\_\_\_

DIABETIC \_\_\_\_\_

EPILEPTIC \_\_\_\_\_

OTHER \_\_\_\_\_

HOSPITAL PREFERENCE \_\_\_\_\_

In the event parents cannot be reached, call:

NAME \_\_\_\_\_

PHONE # \_\_\_\_\_

NAME \_\_\_\_\_

PHONE # \_\_\_\_\_