

**AUTHORIZATION TO HAVE MINORS TREATED**

This form is to be completed by the parents or legal guardians of the athlete and/or managers and returned to the athlete's coach prior to, or on the first day of practice. If it is not returned the athlete will NOT be able to participate. The coach is responsible for keeping this form with them at all team functions.

If your child becomes sick or gets injured, all reasonable efforts will be made to contact you and obtain your consent for medical care. However, the situation may arise whereas a delay to obtain parental consent would result in a delay, which would increase the risk to the child's life or health. All athletic activities have potential risks and despite safety precautions, accidents and illnesses may occur.

Please fill in this form carefully and neatly. If you know you are not going to be available for an extended period of time (hospitalization, vacation, business trip, etc.), while your child is going to be participating in team functions, please notify the coach whom to contact.

A very small number of parents have been reluctant to complete this form for fear of "signing away the rights of a minor". I would like to assure you that every effort would be made to contact you in the case of an emergency. If you would like to provide us with any additional information please do so on the back of this form.

Sincerely,

Wanda Joslin, BRCS Athletic Director

Name of Minor: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Identify allergies or special conditions: \_\_\_\_\_

Does your child wear contact lenses? \_\_\_\_\_

I/We, parent(s) legal guardian(s) of the above mentioned minor, do hereby appoint:

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

Phone: \_\_\_\_\_ Sport: \_\_\_\_\_ Level: \_\_\_\_\_

to act in my/our behalf in authorizing unexpected medical care for the above named minor during the period of his/her participation

On the 20\_\_\_\_ Beaver River Central School \_\_\_\_\_ team.

Signature of consenting parent(s)/ guardian(s): \_\_\_\_\_

Realizing that the above mentioned coach may not be able to contact me/us by using the information on this sheet, and realizing that rapid action by the coach and emergency personnel may save my child unnecessary pain and suffering, I/We still do not want any medical procedures over and above basic emergency care performed on my/our child.

Signatures of parent(s)/guardians(s) refusing care: \_\_\_\_\_

(Everyone must fill in the remainder of this form.)

This document shall be presented to a physician, dentist, or appropriate hospital representative at such a time as emergency medical, dental, surgical care or hospitalization may be required.

Hospitalization coverage carried on the minor:

Insurance company: \_\_\_\_\_ I.D. or Contact #: \_\_\_\_\_

Family physician:  
Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Local Hospital Preference: \_\_\_\_\_

Parent/Guardian:  
Name: \_\_\_\_\_ Address: \_\_\_\_\_

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

Signature: \_\_\_\_\_