



## CONSENT FOR TREATMENT

*Each Player must complete and have signed*

Name of Player \_\_\_\_\_ Player's Age \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

List of Any Allergies \_\_\_\_\_

Required Medication \_\_\_\_\_

Name of League **Waretown Thunder Softball Club**

League Accident Insurance Company **Nationwide Life Insurance Comp**

League Accident Insurance Policy No. **SPP0003548700**

In case of an accident or illness, I hereby authorize a representative of Babe Ruth League, Inc. to use his/her judgment in obtaining immediate Medical Care.

DATE \_\_\_\_\_ SIGNED \_\_\_\_\_

*(Parent or Guardian)*

Daytime Phone ( ) \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_ Parents Health Ins. Co. \_\_\_\_\_

Policy # \_\_\_\_\_

(Parents will be notified in case of serious illness or injury as quickly as they can be reached, but this will make immediate treatment possible.)