ELK RAPIDS SOCCER CLUB

AUTHORIZATION TO PROVIDE MEDICAL CARE

TO ANY HOSPITAL OR MEDICAL PROVIDER:

This document constitutes my authorization and consent for you to provide any and all medical and nursing care which you deem necessary or appropriate and in the best interest of my child:

Child's Full Name: _____________________________________ Date Of Birth (Month/Day/Year): _________________

I represent to you that I have legal authority to authorize and to consent to such medical care. I further authorize the bearer of this document to execute on my behalf any and all Consent For Treatment forms, including Informed Consent forms for invasive procedures, which may be required as a condition of treatment.

This authorization is effective this _______ day of _________________, 20___ and shall remain in effect until July 1, 2017.

My child's personal physician is:

Physician's Name: ______________________________________ Telephone #: ______________________

Address: ____

City, State, Zip Code: ____

My child's insurance information is:

Insurer/HMO/PPO: _______________________________________ Policy #: __________ Group #: __________

Name of Insured: ____

My Child's ALLERGIES are: ____

My Child's MEDICAL CONDITIONS and/or RECENT INJURIES are: ____________________________

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Date of my child's last tetanus shot: _________________________

A copy of this Authorization shall have the same force and effect as the original.

Signature: ____

Print Name: ____ Relationship To Child: __________________

Address: _______________________________________ City, State, Zip: ______________________________

Home Phone: ____/________________Business Phone: ____/_______________Cell Phone: _________________

Emergency contact person other than parent – Name/Relationship: _______________________________________

Phone: ____/__________________

Subscribed and sworn before me on this _______ day of _________________, 20___.

Notary Public: ____________________________________ My Commission Expires On: _____________________