



BRIDGEWATER YOUTH SOCCER ASSOCIATION, INC

CONSENT FOR MEDICAL TREATMENT

PLAYER NAME _____ DOB ____/____/____

ADDRESS _____

TOWN _____ STATE _____ ZIP _____

INSURANCE COMPANY _____

NAME OF POLICY HOLDER _____

POLICY # _____

DOCTOR _____ PHONE# _____

MEDICATIONS _____

ALLERGIES _____

PARENTS NAME _____

ADDRESS (IF DIFFERENT) _____

TOWN _____ STATE _____ ZIP _____

HOME PHONE# _____ CELL# _____

WORK# _____ BEEPER# _____

EMERGENCY CONTACT _____ PHONE# _____

As Parent or Legal Guardian of the above named player, I hereby give my consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve life, limb, or well being of my dependent.

PRINT NAME

SIGNATURE

DATE