HRSA, HATTRIX SOCCER
PLAYER MEDICAL TREATMENT AUTHORIZATION
COACHES MUST CARRY THESE SIGNED FORMS AT ALL GAMES & PRACTICES

Player's Name: ______________________________ Date of Birth: ____________________

Coach's Name: ______________________________ Age Group: _____________________

Consent for Medical Treatment (Minor)

As a 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 whenever conditions are necessary to preserve the life, limb, or well being of my dependent.

Parent's signature: ______________________________________ Date: ___________________

List of any Medical Problems or Restrictions:

____

____

____

Person to Notify in Emergency: __________________________ Telephone: _______________

Doctor to Notify in Emergency: __________________________ Telephone: ______________

---cut along this line-------------------------------------

HRSA, HATTRIX SOCCER
PLAYER MEDICAL TREATMENT AUTHORIZATION
COACHES MUST CARRY THESE SIGNED FORMS AT ALL GAMES & PRACTICES

Player's Name: ______________________________ Date of Birth: ____________________

Coach's Name: ______________________________ Age Group: _____________________

Consent for Medical Treatment (Minor)

As a 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 whenever conditions are necessary to preserve the life, limb, or well being of my dependent.

Parent's signature: ______________________________________ Date: ___________________

List of any Medical Problems or Restrictions:

____

____

____

Person to Notify in Emergency: __________________________ Telephone: _______________

Doctor to Notify in Emergency: __________________________ Telephone: ______________