



### CONSENT FOR TREATMENT

Each Player must complete and have signed all 4 copies (1 sheet).

Name of Player \_\_\_\_\_ Player's Age   
Home Address \_\_\_\_\_ City \_\_\_\_\_ State   
Family Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

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

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

Name of League \_\_\_\_\_

League Accident Insurance Company \_\_\_\_\_

League Accident Insurance Policy No. \_\_\_\_\_

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



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