<u>EAU GALLIE LITTLE LEAGUE</u>
<u>EMERGENCY MEDICAL AUTHORIZATION CONSENT</u>

To be carried by Team Manager

PLAYER: ____ BIRTH DATE: ___________

ADDRESS: ____

PARENT/GUARDIAN:
HOME PHONE: _________________ WORK PHONE: _______________ EXTRA: __________

In the event reasonable attempts to contact parents/guardians to authorize the provision of emergency treatment and transportation for their child who may become ill/injured while under the Eau Gallie League's authority , I hereby consent for the administration of treatment deemed medical necessary. Our preferred physician is ___________________________ or_____________________________
In the event that the preferred practitioner is not available, the licensed physician or dentist on staff will be used. Our preferred hospital is____
In the event that the preferred hospital is not accessible the area hospital will be utilized.

This authorization does not cover major surgery unless it be deemed a life or death situation. Should this "Life or Death" situation occur it must be confirmed by a minimum of two licensed physicians , concurring the necessity for such surgery.

ALLERGIES: ____

SURGERIES PAST 5 YEARS: ____

PHYSICAL IMPAIRMENTS: ____

____
Parent/Guardian signature and date

____

____
Address