

Local Club Use Only

# MEDICAL CONSENT FORM

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_

Cell Phone # \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Medical insurance \_\_\_\_\_ Policy # \_\_\_\_\_

Father's Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Office Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Medical insurance \_\_\_\_\_ Policy # \_\_\_\_\_

Mother's Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Office Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Medical insurance \_\_\_\_\_ Policy # \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

## MEDICAL HISTORY

Weight \_\_\_\_\_ Height \_\_\_\_\_ Last Tetanus shot \_\_\_\_\_

Food allergies \_\_\_\_\_

Medication allergies \_\_\_\_\_

Medications receiving now \_\_\_\_\_

Medical history (i.e., recent surgery, diabetic, chronic illness) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Person to notify in case of accident or illness if parents are not available

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Relationship to child: \_\_\_\_\_

I, \_\_\_\_\_, (parent/guardian) give the following emergency medical treatment consent for the above named child. Effective from date of \_\_\_\_\_ to \_\_\_\_\_.

Signature of Parent/Guardian \_\_\_\_\_

Date: \_\_\_\_\_