AUTHORIZATION FOR MINOR'S MEDICAL TREATMENT

Child Full Legal Name:_____
Date of Birth: _____ Gender: _____

Doctor's Information:
Doctor's Name: _____
Doctor's Address: _____
Doctor's Office Phone: _____ Doctor's Emergency Phone: _____
Medical Insurer/Health Plan: _____ Policy #: _____
Allergies to Medications: _____
Allergies (Other): _____
If applicable, please note the conditions for which the child is currently receiving treatment:
_____
Note any other significant medical information: _____
Dentist's Information:
Dentist's Name: _____
Dentist's Address: _____
Dentist's Office Phone: _____ Dentist's Emergency Phone: _____
Dentist's Insurer/Health Plan: _____ Policy #: _____

Parent(s)/Legal Guardian(s):
Parent #1:
Name:_____
Address: _____
Home phone: _____ Work phone: _____
Cell phone: _____ Other phone: _____
Email: _____
Additional Contact Information: _____
_____

Parent #2:
Name:_____
Address: _____
Home phone: _____ Work phone: _____
Cell phone: _____ Other phone: _____
Email: _____
Additional Contact Information: _____
_____

Alternate contact in the event Parent(s)/Legal Guardian(s) cannot be reached:
Name: _____
Address: _____
Home phone: _____ Work phone: _____
Cell phone: _____ Other phone: _____
Email: _____
Additional Contact Information: _____
_____

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

I do hereby solemnly swear that I have legal custody of the aforementioned minor child. The undersigned _____, referred to as the parent and lawful guardian of _____, a minor.

Parent's acknowledges that said minor is authorized to travel with the Warriors Nation Basketball (Reaching All Youth, Inc) and to engage in all activities.

I grant my authorization and consent for the Coaches of Warriors Nation Basketball (Reaching All Youth) (hereafter "Supervising Adult") to administer general first aid treatment for any minor injuries or illnesses experienced by the minor. If the injury or illness is life threatening or in need of emergency treatment, I authorize the Supervising Adult to summon any and all professional emergency personnel to attend, transport, and treat the participant and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur.

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of the Supervising Adult in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

This authorization is effective and expires one full year from the date signed on this form.

Signed this _____day of_____, 20 ____.

_____

Parent #1's Signature

_____

Parent #2's Signature