Authorization for Medical/Dental Treatment

PLAYER INFORMATION

Player Name: ____
Address: ____
City: _______________ Zip code: ________ Emergency Phone: ___________
Home Phone: ____________Cell: ______________ Work: _____________
Email Address: ____
Parents Name: ____

AUTHORIZATION FOR MEDICAL/DENTAL TREATMENT

I, the undersigned, the parent and/or legal guardian of (if player is a minor), or the person (if player is age of majority), ________________________ (player) hereby grant permission for the Native Stars Basketball, coaches, and trainers, to authorize medical or dental treatment for the player by any available and qualified physician/dentist or other trained medical personnel. In addition, this permission extends to and includes authorization for emergency treatments, procedures, and surgeries for the player. Furthermore, on-going medical treatment is authorized until such time as the undersigned shall dismiss these physicians/medical personnel in writing and have engaged another qualified physician. This permission and authorization includes admission to a hospital or medical facility if the attending physician deems it necessary. I further testify that I am the parent/legal guardian of the child listed above and have the right to give such permission.

PARENT OR GUARDIAN: ___________________________ Date: ___________

INSURANCE COMPANY INFORMATION

The above child is fully covered by my/our insurance company:

INSURANCE COMPANY: ____
ADDRESS: ____
PHONE: ____
POLICY NUMBER: ____

OTHER PERTINENT MEDICAL INFORMATION: (medication, allergies, injuries, surgeries, ect.)

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IN CASE OF EMERGENCY IF PARENT OR GUARDIAN CANNOT BE REACHED,

PLEASE CONTACT: ____
HOME PHONE: ________________ CELL PHONE: __________________
ADDRESS: ____
EMAIL ADDRESS: ____