Bel-Mateo Babe Ruth Baseball ▪ P.O. Box 234 ▪ Belmont, CA 94002

CONSENT FOR MEDICAL TREATMENT

For the protection of my child participating in Bel-Mateo Babe Ruth League, I, the parent/guardian of

_____, hereby authorize the manager, coach, or other representative of Bel-Mateo Babe Ruth League to use his/her judgment in obtaining immediate medical care. These persons have my permission to take my child to the hospital or dentist for the treatment of injury. I understand I will be notified as quickly as I can be reached, but this form will make immediate treatment possible. I agree to be responsible for all expenses and assign payment for all expenses to my medical insurance in the event of any injury sustained by my child requiring medical attention while participating in Bel-Mateo Babe Ruth League.

Parent/Guardian Name: (Please Print) _____

Parent/Guardian Signature: _____ Date:_____

Player Name: _____ Date of Birth: _____ Age:_____

Address:_____ City: _____ Home: (_____)_____

Mom's Name: _____ Mom's Cell: (_____)_____

Dad's Name: _____ Dad's Cell: (_____)_____

Emerg. Contact (not Mom/Dad): _____ Cell:(_____)_____

Allergies or other medical conditions: _____

Required Medication:_____

Primary Insurance Coverage Information

_____ _____
Name of Employer Work Phone

_____ _____
Insurance Company Insurance Policy/Card Number

_____ (_____)_____
Doctor Name Doctor Phone

_____ (_____)_____
Dentist Name Dentist Phone