AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT & EMERGENCY CONTACT INFO

PCA, Inc., Crystal Lake Babe Ruth Baseball League, Inc. & Crystal Lake Park District

As a parent and/or guardian, I do herewith authorize the treatment by a qualified and licensed medical doctor of the following minor in the event of a medical emergency which, in the opinion of the attending physician may endanger his or her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Name of Minor:_____ **Birthdate:**_____ **Relationship:**_____

Date(s) when release is intended: 2017 PCA & CLBR Fall Baseball Season

Home Address: _____ City:_____ Zip:_____

Home Phone: _____

Father's Name: _____ Father's Cell #: _____ Father's Work #: _____

Mother's Name: _____ Mother Cell #: _____ Mother's Work #: _____

In case of emergency, please contact: _____ Relationship: _____

Emergency Contact Phone Number: _____

Physician to be called in an emergency: Name:_____ Phone:_____

Dentist to be called in an emergency: Name:_____ Phone:_____

Hospital of choice:_____

Special Information (development concerns, habits, allergies, medical attention, medications, etc.):

_____

_____

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_____

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

IF REGISTERING VIA FAX, YOUR FACSIMILE SIGNATURE SHALL SUBSTITUTE FOR AND HAVE THE SAME LEGAL EFFECT AS AN ORGINIAL FORM SIGNATURE.

X_____ _____

Signed (Parent/Legal Guardian) **Date**