Print Form

# CONSENT FOR TREATMENT

*Each Player must complete and have signed*

**Name of Player**__________________________ **Player's Age**__________

**Home Address**__________________________ **City**______________ **State**________

**Family Physician**__________________________ **Phone**______________

**List of Any Allergies**__________________________

**Required Medication**__________________________

**Name of League** South Orlando Babe Ruth League aka SAY Baseball of Central Florida Inc.

**League Accident Insurance Company** Federal Insurance Co.

**League Accident Insurance Policy No.** 9907-0913

In case of an accident or illness, I hereby authorize a representative of Babe Ruth League, Inc. to use his/her judgment in obtaining immediate Medical Care.

DATE______________ SIGNED__________________________

*(Parent or Guardian)*

Daytime Phone (     )__________________ Home Phone (     )__________________

Cell Phone (     )__________________ Parents Health Ins. Co.__________________

Policy #__________________

(Parents will be notified in case of serious illness or injury as quickly as they can be reached, but this will make immediate treatment possible.