CONSENT FOR MEDICAL TREATMENT

ATHLETE NAME: _____

circle team Youth (3/4) Junior (5/6) Senior (7/8)

Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examinations and/or immunizations for the above-named athlete. In the event of serious illness, significant accidental injury, or the need for major surgery, I understand that every attempt will be made by the attending physician to contact me in the quickest way possible. If the physician is not able to reach me, the treatment necessary for the best interest of the above-named athlete may be given. Portsmouth Youth Football does not have any responsibility for payment of medical treatment and the Player's Parent(s) or Guardian(s) will have sole responsibility for any and all medical bills and charges.

In the event that an emergency arises during a practice session, I understand that an effort will be made to contact me as soon as possible. I grant my permission to Portsmouth Youth Football to provide necessary emergency treatment to the athlete prior to admission to a medical facility.

I am aware that the information provided below will be shared with coaches in order to ensure the safety of all athletes during practice and at games and competitions. The information will be kept confidential and retained by the coaches to be used in the event of a medical emergency.

Parent/Guardian Signature Date

Parent/Guardian Name Parent/Guardian Phone

Parent/Guardian Name Parent/Guardian Phone

Physician Physician Phone

Addl Emergency Contact Relationship Phone

Allergies

Medications

Known Medical Conditions