

AUTHORIZATION TO CONSENT FOR TREATMENT OF A MINOR

I hereby grant to I. C. Coaches authority to give an informed consent for the treatment of \_\_\_\_\_, age \_\_\_\_\_, should such child require medical care because of any condition or incident, except that major surgery and \_\_\_\_\_ and should not be performed without my consent unless: (1) two physicians are of the medical opinion that such procedures are necessary to relieve the suffering or preserve the life or limb of my child; or (2) I cannot be reached after reasonable attempts.

Facts concerning the child's medical history including allergies, physical impairments and medications being taken to which a physician should be alerted are as follows:

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Our family physician is Dr. \_\_\_\_\_ Phone: \_\_\_\_\_

Our family dentist is Dr. \_\_\_\_\_ Phone: \_\_\_\_\_

Our hospital of choice is \_\_\_\_\_

Our health insurance plan is \_\_\_\_\_ I.D . # : \_\_\_\_\_

Other: \_\_\_\_\_

This authorization expires upon completion of the last golf, football, soccer, volleyball, basketball, baseball, cheerleading, softball and/or track game and/or event wherein my child is involved as a player but in no event shall it extend beyond July 1, 20\_\_\_\_.

Date: \_\_\_\_\_

Signature of Parent or Legal Guardian(s)

\_\_\_\_\_

Printed Name of Parent or Legal Guardian(s)

\_\_\_\_\_

Address

\_\_\_\_\_