

Marshall Area Fastpitch Softball Association

Emergency Care Permission Form

Athlete's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

As parent or guardian of the above named athlete, I hereby authorize the staff (both paid and volunteer) of Marshall Area Fastpitch Softball Association to provide care, including authority for medical transportation, in the event of injury or illness. I also authorize qualified medical personnel to provide emergency medical care in the event of an emergency.

Parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_

E-mail Address \_\_\_\_\_

Emergency Contact #1 \_\_\_\_\_

Relationship to Athlete \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_

Please list any medical needs the athlete may have, such as allergies, chronic illness, medications taken, asthma, contact lenses, hearing aids, etc. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

Marshall Area Fastpitch Softball Association

Liability Waiver

We, the undersigned, fully understand that we accept all liability and responsibility for our daughter while traveling to and from and playing softball with a Marshall Area Fastpitch Association club team, camp, or clinic. Under no situations will the coach, assistants, or sponsors be held liable for any injury or accident. Each player/participant is responsible for his/her own individual insurance.

We, the undersigned, fully understand the above statement and are in agreement with it.

Signed \_\_\_\_\_  
(parent/guardian signature)

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT FOR MINOR CHILD

We, \_\_\_\_\_ and \_\_\_\_\_ of \_\_\_\_\_,  
Father Mother City

\_\_\_\_\_ County, Minnesota, do hereby state that we are parent or legal guardians

having custody of \_\_\_\_\_, a minor, born \_\_\_\_\_,  
Minor's full name date

who resides with us at \_\_\_\_\_.  
Address

We authorize and consent to any x-rays, examinations, anesthetics, medical or surgical diagnosis or treatment and hospital care to be rendered to \_\_\_\_\_  
Minor's full name

under the general or special supervision physician or surgeon licensed to practice in the healing arts, when the need for such treatment is immediate, and when efforts to contact us were unsuccessful.

Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Allergies \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_