

# Warrington Baseball Organization

## Emergency Transportation & Treatment Form

<b>Child's Name:</b>	<b>Parent's ~ Guardian's Name:</b>
Age:	Home phone:
Date of birth:	Work phone:
Insurance Carrier:	Cell phone:
Insurance Carrier Grp #:	Alternate Phone (any type):
<b>Medical Conditions ~ Allergies ~ Medications</b>	<b>Alternative Contacts</b>
<b>Medical Conditions:</b>	<b>Alternate Contact's Name:</b>
Other:	Relationship to Child:
Allergies:	Home phone:
Current medications:	Work phone:
Past Injuries/Surgeries:	Cell phone:
<b>Family Doctor ~ Specialists ~ Hospital</b>	<b>Alternate Contact's Name:</b>
<b>Family Doctor Name:</b>	Relationship to Child:
Family Doctor Practice:	Home phone:
Doctor's phone:	Work phone:
Specialist Name (1):	Cell phone:
Specialist Number (1):	<b>Alternate Contact's Name:</b>
Specialist Name (2):	Relationship to Child:
Specialist Number (2):	Home phone:
Hospital Choice:	Work phone:
Hospital Number:	Cell phone:

In the event of a medical emergency, I \_\_\_\_\_ hereby grant authorization to Warrington Baseball to have my child \_\_\_\_\_ transported & treated at this medical facility for patient care treatment. Although \_\_\_\_\_ is my preferred facility for treatment, if immediate treatment requires going to a different medical facility, you have my (our) permission to do so.

**Special Notes:**

<b>Parent / Guardian Signature &amp; Date</b>	<b>Brother / Sister Signature &amp; Date - Must be 18 years or older</b>
<b>Grandparent Signature &amp; Date</b>	<b>Aunt / Uncle Signature &amp; Date - Must be 18 years or older</b>

**NOTES:**

- 1) In the section titled Medical Conditions, please put things like Asthma, Diabetes, Pacemakers, etc.
- 2) Aunt, Uncle, Brother, & Sister MUST be over 18 years old.
- 3) EVERY section must be filled out or acknowledged.

# Warrington Baseball Organization

## *Emergency Testing & Diagnostic Approval Form*

**Child's name:** \_\_\_\_\_

**Age:** \_\_\_\_\_

**Date of birth:** \_\_\_\_\_

**Insurance Carrier:** \_\_\_\_\_

**Insurance Carrier Grp #:** \_\_\_\_\_

### Medical Testing & Diagnostics

Any X-rays, CAT scans, MRI, or other imaging	Signature for Approval & Relationship to Child - Date
Any blood to be drawn for testing purposes	Signature for Approval & Relationship to Child - Date
EKG or EEG	Signature for Approval & Relationship to Child - Date
Any other lab testing that requires (other) bodily fluids to be extracted or used for injury determination.	Signature for Approval & Relationship to Child - Date

In the event of a medical emergency, I \_\_\_\_\_ hereby grant authorization to have the approved testing and diagnostics performed on my child \_\_\_\_\_ for injury determination and patient care treatment.

***Special Notes:***

Parent / Guardian Signature & Date	Brother / Sister Signature & Date - Must be 18 years or older
Grandparent Signature & Date	Aunt / Uncle Signature & Date - Must be 18 years or older