



## CONSENT TO TREAT MINOR

I, \_\_\_\_\_, parent or legal guardian of \_\_\_\_\_, do hereby consent to any medical care and the administration of anesthesia determined by a physician to be necessary for the welfare of my child while said child is under the care of a coach or representative of the **Park City Lacrosse Organization** and I am not reasonably available by telephone to give consent.

This authorization is effective from August 1, 20\_\_\_\_ to July 31, 20 \_\_\_\_.

Signature of Parent or Legal Guardian \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Name (please print): \_\_\_\_\_

**This consent form should be taken with the child to the hospital or physician's office when the child is taken for treatment.**

The following information will assist in treatment but is not required:

Family address \_\_\_\_\_

Telephone: Father \_\_\_\_\_ Mother \_\_\_\_\_

Child's Birthdate \_\_\_\_\_ Last Tetanus \_\_\_\_\_

Allergies to drugs or foods \_\_\_\_\_

Special medications, blood type or other pertinent information

\_\_\_\_\_

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