



AMERICAN YOUTH FOOTBALL
Emergency Medical Treatment, Consent and Information
 ASSOCIATION NAME - Leyden Bears

 (child's name) Has My Permission To Participate In Any And All,

 (association name) And, American Youth Football, Inc / American
 And/Or Fundraising Activities. I Further Hereby Authorize Any First Aid, Emergency Treatment, Including But Not Limited To, Athletic, Social
 Transportation To And From Health Care Facilities And/Or Any Licensed Physician To Provide Treatment, Order Injections,
 Hospitalize, Give Anesthesia Or Perform Surgery, I Understand That This Authorization Is Given Prior To Any Need For Medical
 Care, But Given To Avoid Unnecessary Delay In Emergency Treatment Which The Physician May Deem Advisable In The
 Exercise Of Best Judgment. I Presume A Reasonable Attempt Was Made To Contact Me.

EMERGENCY MEDICAL INFORMATION

The Following Information Will Be Used In The Event That A Parent / Legal Guardian Is Not Available. The Purpose Of This
 Information Is To Provide A Quick Reference For Medical Personnel Should The Need Arise. Please Fill Out This Form
 Completely. If A Particular Question Is Not Applicable Write "None", N/A, Or Other Appropriate Comment otherwise NONE will be
 assumed. If Additional Space Is Needed, Please Use The Back Of This Form. All Information Disclosed Here Will Be Treated As
 Confidential. It Will Be The Responsibility Of The Parent/legal Guardian To Notify The Participants Coach And League/Event
 Officials If Any Information Needs To Be Added, Deleted, Changed, Or Updated In Any Way. Please Keep A Copy For Your
 Records.

Participants Name: _____ Nick Name _____ Hm Phone: _____
 Street Address: _____ City / Town: _____ State: _____ Zip: _____
 Email: _____
 Father's Name: _____ City / Town: _____ State: _____ Zip: _____
 Street Address: _____ City / Town: _____ State: _____ Zip: _____
 Employer: _____ Hm Phone: _____ Wk Phone: _____ Cell : _____
 Email: _____
 Mother's Name: _____ City / Town: _____ State: _____ Zip: _____
 Street Address: _____ City / Town: _____ State: _____ Zip: _____
 Employer: _____ Hm Phone: _____ Wk Phone: _____ Cell : _____
 Family Medical Insurance: _____ Family Physician: _____
 Carrier: _____ Name: _____
 Group: _____ Address: _____
 Policy #: _____ Phone Number: _____
 Group #: _____ Alt Phone: _____
 ID#: _____
 Preferred Hospital: (1) _____ (2) _____

EMERGENCY CONTACTS: (MUST HAVE AT LEAST TWO CONTACTS)
 Name: _____ Phone #: _____ Relationship to Player _____
 Name: _____ Phone #: _____ Relationship to Player _____

Please List Any Medical Conditions (Allergies, Asthma, Etc.) And Medications Being Taken By The Participant Named Above.
 Please List Any Other Information You May Deem Relevant, And Helpful To Emergency Medical Personnel: (Please Note If No
 Information Is Given And The Words "None" Or "N/A" Is Not Filled In Then, "None" Will Be Assumed.

I HAVE READ, REVIEWED FOR ACCURACY, UNDERSTOOD, ACCEPTED AND AGREED TO THE ABOVE:

*Print Parent/Legal Guardian Name

*Signature Parent/Legal Guardian

*Date