

# Youth Baseball Team Emergency Medical Form

**Team Name:** \_\_\_\_\_ **Level** \_\_\_\_\_

In the event of an emergency and I cannot be reached, I authorize the coach or his/her designee to seek emergency treatment for my child listed below. This may include transporting, by ambulance, to a health care facility.

<b>Name:</b> _____	<b>Address:</b> _____
<b>Parent #1 Name:</b> _____	<b>Phone #:</b> _____
<b>Parent #2 Name:</b> _____	<b>Phone #:</b> _____
<b>Contact #3 Name:</b> _____	<b>Phone #:</b> _____
<b>Medical History</b> Circle <b>YES</b> or <b>NO</b> : Asthmatic (inhaler) Y or N Epilepsy Y or N Diabetes Y or N Allergies Y or N List _____	
<b>Signature Parent/Guardian:</b> _____ <b>Date:</b> _____	
<hr/>	
<b>Name:</b> _____	<b>Address:</b> _____
<b>Parent #1 Name:</b> _____	<b>Phone #:</b> _____
<b>Parent #2 Name:</b> _____	<b>Phone #:</b> _____
<b>Contact #3 Name:</b> _____	<b>Phone #:</b> _____
<b>Medical History</b> Circle <b>YES</b> or <b>NO</b> : Asthmatic (inhaler) Y or N Epilepsy Y or N Diabetes Y or N Allergies Y or N List _____	
<b>Signature Parent/Guardian:</b> _____ <b>Date:</b> _____	
<hr/>	
<b>Name:</b> _____	<b>Address:</b> _____
<b>Parent #1 Name:</b> _____	<b>Phone #:</b> _____
<b>Parent #2 Name:</b> _____	<b>Phone #:</b> _____
<b>Contact #3 Name:</b> _____	<b>Phone #:</b> _____
<b>Medical History</b> Circle <b>YES</b> or <b>NO</b> : Asthmatic (inhaler) Y or N Epilepsy Y or N Diabetes Y or N Allergies Y or N List _____	
<b>Signature Parent/Guardian:</b> _____ <b>Date:</b> _____	
<hr/>	
<b>Name:</b> _____	<b>Address:</b> _____
<b>Parent #1 Name:</b> _____	<b>Phone #:</b> _____
<b>Parent #2 Name:</b> _____	<b>Phone #:</b> _____
<b>Contact #3 Name:</b> _____	<b>Phone #:</b> _____
<b>Medical History</b> Circle <b>YES</b> or <b>NO</b> : Asthmatic (inhaler) Y or N Epilepsy Y or N Diabetes Y or N Allergies Y or N List _____	
<b>Signature Parent/Guardian:</b> _____ <b>Date:</b> _____	
<hr/>	
<b>Name:</b> _____	<b>Address:</b> _____
<b>Parent #1 Name:</b> _____	<b>Phone #:</b> _____
<b>Parent #2 Name:</b> _____	<b>Phone #:</b> _____
<b>Contact #3 Name:</b> _____	<b>Phone #:</b> _____
<b>Medical History</b> Circle <b>YES</b> or <b>NO</b> : Asthmatic (inhaler) Y or N Epilepsy Y or N Diabetes Y or N Allergies Y or N List _____	
<b>Signature Parent/Guardian:</b> _____ <b>Date:</b> _____	
<hr/>	
<b>Name:</b> _____	<b>Address:</b> _____
<b>Parent #1 Name:</b> _____	<b>Phone #:</b> _____
<b>Parent #2 Name:</b> _____	<b>Phone #:</b> _____
<b>Contact #3 Name:</b> _____	<b>Phone #:</b> _____
<b>Medical History</b> Circle <b>YES</b> or <b>NO</b> : Asthmatic (inhaler) Y or N Epilepsy Y or N Diabetes Y or N Allergies Y or N List _____	
<b>Signature Parent/Guardian:</b> _____ <b>Date:</b> _____	