

Authorization for Medical Treatment

1) I am the _____ (father) _____ (mother) _____ (legal guardian) _____ of the minor child listed below:

Name of Child	Date of Birth

2) The child listed above resides with me at _____
(Street Address)

3) From time to time, I place my child (listed above) in the care and custody of the following individuals:

Name	Address	Relationship	Telephone

4) Any known allergies (to medication and otherwise) and medication my child is presently taking are as follows:

Allergies or Known Allergic Reactions	Present Medication

The child listed above CANNOT take the following pain reliever(s)

Bayer Bufferin Tylenol Advil Motrin Aleve Orudis KT Actron Excedrin Other: _____

5) Provided the medical care and treatment of my child is on the advice of a licensed physician, I authorize and request all physicians, hospitals, or other providers of medical services to follow the instructions of any person listed in the preceding paragraph 3, at any time and under any circumstances whatsoever.

6) The child is covered (if applicable) under the following group medical plan:

Employer	Insurance Company	Plan Number

7) The child's doctor is:

Name of Doctor	Address	Telephone

8) In consideration of the benefits to be derived thereby and having full confidence that every reasonable precaution will be taken to assure her safety and well being during this activity, I voluntarily waive all claims against the leaders of this activity, officers, agents, and representatives of the Jupiter/Tequesta Athletic Association (JTAA) and the United States Sports Specialty Association (USSSA).

Date: _____

Signature

STATE OF FLORIDA
 COUNTY OF PALM BEACH

Sworn to and subscribed before me
 this ____ day of _____, 20__

 Notary Public, State of Florida at Large