



### CONSENT FOR TREATMENT

**#1** This original for team credentials.

*Each Player must complete and have signed all 4 copies (1 sheet).*

Name of Player \_\_\_\_\_ Player's Age \_\_\_\_\_  
 Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
 Family Physician \_\_\_\_\_ Phone ( \_\_\_ ) \_\_\_\_\_  
 List of Any Allergies \_\_\_\_\_  
 Required Medication \_\_\_\_\_  
 Name of League \_\_\_\_\_  
 League Accident Insurance Company \_\_\_\_\_  
 League Accident Insurance Policy No. \_\_\_\_\_

In case of an accident or illness, I hereby authorize a representative of Babe Ruth League, Inc. to use his/her judgment in obtaining immediate Medical Care.

DATE \_\_\_\_\_ SIGNED \_\_\_\_\_  
*(Parent or Guardian)*

Daytime Phone ( \_\_\_ ) \_\_\_\_\_ Home Phone ( \_\_\_ ) \_\_\_\_\_

Cell Phone ( \_\_\_ ) \_\_\_\_\_

(Parents will be notified in case of serious illness or injury as quickly as they can be reached, but this will make immediate treatment possible.)



### CONSENT FOR TREATMENT

**#2** This original for State Tournament.

*Each Player must complete and have signed all 4 copies (1 sheet).*

Name of Player \_\_\_\_\_ Player's Age \_\_\_\_\_  
 Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
 Family Physician \_\_\_\_\_ Phone ( \_\_\_ ) \_\_\_\_\_  
 List of Any Allergies \_\_\_\_\_  
 Required Medication \_\_\_\_\_  
 Name of League \_\_\_\_\_  
 League Accident Insurance Company \_\_\_\_\_  
 League Accident Insurance Policy No. \_\_\_\_\_

In case of an accident or illness, I hereby authorize a representative of Babe Ruth League, Inc. to use his/her judgment in obtaining immediate Medical Care.

DATE \_\_\_\_\_ SIGNED \_\_\_\_\_  
*(Parent or Guardian)*

Daytime Phone ( \_\_\_ ) \_\_\_\_\_ Home Phone ( \_\_\_ ) \_\_\_\_\_

Cell Phone ( \_\_\_ ) \_\_\_\_\_

(Parents will be notified in case of serious illness or injury as quickly as they can be reached, but this will make immediate treatment possible.)



### CONSENT FOR TREATMENT

**#3** This original for Regional Tournament.

*Each Player must complete and have signed all 4 copies (1 sheet).*

Name of Player \_\_\_\_\_ Player's Age \_\_\_\_\_  
 Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
 Family Physician \_\_\_\_\_ Phone ( \_\_\_ ) \_\_\_\_\_  
 List of Any Allergies \_\_\_\_\_  
 Required Medication \_\_\_\_\_  
 Name of League \_\_\_\_\_  
 League Accident Insurance Company \_\_\_\_\_  
 League Accident Insurance Policy No. \_\_\_\_\_

In case of an accident or illness, I hereby authorize a representative of Babe Ruth League, Inc. to use his/her judgment in obtaining immediate Medical Care.

DATE \_\_\_\_\_ SIGNED \_\_\_\_\_  
*(Parent or Guardian)*

Daytime Phone ( \_\_\_ ) \_\_\_\_\_ Home Phone ( \_\_\_ ) \_\_\_\_\_

Cell Phone ( \_\_\_ ) \_\_\_\_\_

(Parents will be notified in case of serious illness or injury as quickly as they can be reached, but this will make immediate treatment possible.)



### CONSENT FOR TREATMENT

**#4** This original for World Series.

*Each Player must complete and have signed all 4 copies (1 sheet).*

Name of Player \_\_\_\_\_ Player's Age \_\_\_\_\_  
 Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
 Family Physician \_\_\_\_\_ Phone ( \_\_\_ ) \_\_\_\_\_  
 List of Any Allergies \_\_\_\_\_  
 Required Medication \_\_\_\_\_  
 Name of League \_\_\_\_\_  
 League Accident Insurance Company \_\_\_\_\_  
 League Accident Insurance Policy No. \_\_\_\_\_

In case of an accident or illness, I hereby authorize a representative of Babe Ruth League, Inc. to use his/her judgment in obtaining immediate Medical Care.

DATE \_\_\_\_\_ SIGNED \_\_\_\_\_  
*(Parent or Guardian)*

Daytime Phone ( \_\_\_ ) \_\_\_\_\_ Home Phone ( \_\_\_ ) \_\_\_\_\_

Cell Phone ( \_\_\_ ) \_\_\_\_\_

(Parents will be notified in case of serious illness or injury as quickly as they can be reached, but this will make immediate treatment possible.)