



Zion Benton Youth Football, Inc.



Emergency Medical Authorization

Purpose:

For parents/guardians to authorize emergency treatment for children who become injured while under the ZBYFL authority, when parents cannot be reached.

Name of Athlete: _____

Address: _____

City/State/Zip: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Parent/Guardian: _____

In the event reasonable attempts to contact parent/guardian listed above are unsuccessful, I/we, the undersigned, do authorize any hospital, clinic, or licensed physician to treat my/our child and administer medical attention rendered under the direct or special supervision of any member of the medical staff of the hospital, clinic, or doctor's office.

Our preferred Physician is: _____

Physician phone number is: _____

In the event the designated preferred practitioner is not available, we authorize in advance another licensed physician the authority and power to render care in his/her best judgment and the transfer of the child to any hospital reasonably accessible. It is also understood that every effort shall be made to contact the parent/guardian prior to rendering treatment to the athlete, but that treatment will not be withheld if the parent/guardian cannot be contacted.

Signature of Parent/Guardian

Date