

ST. MARYS SOCCER ASSOCIATION
CONSENT FOR EMERGENCY MEDICAL TREATMENT

We the Parents of _____ give permission for emergency medical treatment of our child for illness or accident if we cannot first be contacted.

Emergency Phone: Parent or Guardian:

Name _____ Phone(s) _____

Emergency Contact Other Than Parent:

Name _____ Phone(s) _____

Does your child have any allergies or require any special medication?

No Yes Explain: _____

Parent / Guardian Signature

Date

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