



AMERICAN YOUTH FOOTBALL
Medical Consent Information Form
MILLBURY-SUTTON AYF FOOTBALL
AND CHEER



_____ (childs name) Has My Permission To Participate In Any And All, **MILLBURY-SUTTON AYF FOOTBALL** (association name) And, American Youth Football, Inc / American Youth Cheer DBA Program(S) Sanctioned Event(S), Be They Official Or Un Official, Including But Not Limited To, Athletic, Social And/Or Fundraising Activities. I Further Hereby Authorize Any First Aid, Emergency Treatment, Including But Not Limited To Transportation To And From Health Care Facilities And/Or Any Licensed Physician To Provide Treatment, Order Injections, Hospitalize, Give Anesthesia Or Perform Surgery. I Understand That This Authorization Is Given Prior To Any Need For Medical Care, But Given To Avoid Unnecessary Delay In Emergency Treatment Which The Physician May Deem Advisable In The Exercise Of Best Judgment. I Presume A Reasonable Attempt Was Made To Contact Me.

EMERGENCY MEDICAL INFORMATION

The Following Information Will Be Used In The Event That A Parent / Legal Guardian Is Not Available. The Purpose Of This Information Is To Provide A Quick Reference For Medical Personnel Should The Need Arise. Please Fill Out This Form Completely. If A Particular Question Is Not Applicable Write "None", N/A, Or Other Appropriate Comment otherwise NONE will be assumed. If Additional Space Is Needed, Please Use The Back Of This Form. All Information Disclosed Here Will Be Treated As Confidential. It Will Be The Responsibility Of The Parent/Legal Guardian To Notify The Participants Coach And League/Event Officials If Any Information Needs To Be Added, Deleted, Changed, Or Updated In Any Way. Please Keep A Copy For Your Records.

Participants Name: _____ **Nick Name:** _____ **Hm Phone:** _____
Street Address: _____ **City / Town:** _____ **State:** _____ **Zip:** _____
Father's Name: _____ **Email:** _____
Street Address: _____ **City / Town:** _____ **State:** _____ **Zip:** _____
Employer: _____ **Hm Phone:** _____ **Wk Phone:** _____ **Cell :** _____
Mother's Name: _____ **Email:** _____
Street Address: _____ **City / Town:** _____ **State:** _____ **Zip:** _____
Employer: _____ **Hm Phone:** _____ **Wk Phone:** _____ **Cell :** _____
Family Medical Insurance: _____ **Family Physician:** _____
Carrier: _____ **Name:** _____
Group: _____ **Address:** _____
Policy #: _____ **Phone Number:** _____
Group #: _____ **Alt Phone:** _____
ID#: _____
Preferred Hospital: (1) _____ (2) _____

EMERGENCY CONTACTS: (MUST HAVE AT LEAST TWO CONTACTS)

Name: _____ **Phone #:** _____ **Relationship to Player:** ____
Name: _____ **Phone #:** _____ **Relationship to Player:** ____

Please List Any Medical Conditions (Allergies, Asthma, Etc.) And Medications Being Taken By The Participant Named Above. Please List Any Other Information You May Deem Relevant, And Helpful To Emergency Medical Personnel: (Please Note If No Information Is Given And The Words "None" Or "N/A" Is Not Filled In Then, "None" Will Be Assumed.

I HAVE READ, REVIEWED FOR ACCURACY, UNDERSTOOD, ACCEPTED AND AGREED TO THE ABOVE:

***Print Parent/Legal Guardian Name**

***Signature Parent/Legal Guardian**

***Date**