



EMERGENCY MEDICAL INFORMATION AND TREATMENT RELEASE

Player Name _____ Birthdate _____

Address _____

Home Phone _____ Parent(s) Work Phone(s) _____

Insurance Company _____ Policy Number _____

In case of an emergency and a parent can not be contacted, please contact:

Name _____ Phone Number _____

Does your child wear glasses: _____ or Contacts lenses: _____

Does your child have allergies? If yes, list the allergies and treatment.

Does your child have asthma? If yes, list symptoms and treatment.

Is your child on any medication? If yes, list medication and dosage.

Are there any other medical conditions or previous injuries that the coach should be aware of? _____

Dentist Name: _____ Phone: _____

Doctor Name: _____ Phone: _____

In the event of an injury, I authorize my child's coach _____ to arrange any necessary treatment.

Parent's Signature: _____ Date: _____

Visit us online

WWW.CHGSL.ORG

For more information, send E-mail to

CHGSOFTBALL@COMCAST.NET