

DYFL MEDICAL AUTHORIZATION EMERGENCY CONTACT FORM

Player Name:	Grade:
Birthdate:	
Parent/Guardian Name:	
Address:	
Parent Home Number:	
Parent Cell #1:	
Parent Cell #2:	
Email:	
EMERGENCY CONTACT INFORMATION OTHER THAN PARENT	
Name:	
Address:	
Phone/Cell:	
PLAYER ALLERGY INFORMATION	
List all know allergies:	
Insurance Information	
Insurance Company:	
Group#:	ID#:
Name of Insured:	

In case of a medical emergency, I hereby give permission to Dexter Youth Football and Volunteers to order treatment for my child, including any necessary medical treatment and x-rays. I also hereby give permission to Dexter Youth Football and Volunteers to disclose the information contained on the Emergency Medical Card to medical personnel. I understand that an attempt will be made to reach me by phone when a diagnosis is completed. I agree to pay all medical, hospital, or other expenses which my child or I may incur as a result of such treatment.

Parent Signature

Date Signed

DYFL BOARD INFO ONLY: Team _____