EMERGENCY MEDICAL AUTHORIZATION FORM

I/we, _________________ / ___________________, Parent(s) / Guardian(s) (circle one) of _____________________________________, born on ___________________, do hereby give my/our consent to **Agoura Pony Baseball**, to secure and authorize such emergency medical treatment as the above name might require while under the supervision of provider. I/we also agree to pay all the costs and fees contingent on emergency medical care or treatment for this person as secured or authorized under this consent.

NOTE: Every effort will be made to notify the parent(s) / guardian(s), etc. in case of an emergency.

In the event of an emergency, following are our preferred providers:

Physician's Name: ____________________ Phone Number: ____________________________

Preferred Hospital:____

Address: ______________________________ Phone: _________________________________

If the parent(s) / guardian(s) is unavailable, please make every effort to contact the following in an emergency:

Name: _________________________

Address: _________________________

Phone: ________________________

Relationship: _________________________

Signature of parent(s) / guardian(s) : ___________________ / ___________________

Emergency contact numbers: (1) _______________ *(2)* ________________

Date: _________________________