

**Long Island Braves Baseball**  
**329 Euclid Avenue**  
**Massapequa Park, New York 11762**

AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT FOR MINOR CHILD

I, \_\_\_\_\_, am the Parent of \_\_\_\_\_,  
a minor child who was born on \_\_\_\_\_, and whose present age is \_\_\_\_\_,  
and who resides at \_\_\_\_\_,  
in the County of \_\_\_\_\_, and the State of \_\_\_\_\_.

I authorize \_\_\_\_\_, (phone number) \_\_\_\_\_,  
(please leave space above blank)

an adult who resides at \_\_\_\_\_,  
in the County of \_\_\_\_\_, and the State of \_\_\_\_\_ to consent to emergency treatment which may  
be necessary for my minor child, named above. Such treatment to include, but not limited to, examinations, x-rays and  
laboratory tests, medical and surgical treatment, use of medication, anesthetics, sutures, and admission for hospital care  
as may be required, when efforts to contact me are unsuccessful.

It is understood that such care will be upon advice of a duly licensed physician or surgeon.

Sworn to before me this  
\_\_\_\_\_ day of \_\_\_\_\_, 200\_\_

\_\_\_\_\_  
Notary Signature

\_\_\_\_\_  
Signature of Parent or Legal Guardian

Medical History

Name of child: \_\_\_\_\_

Name of child's doctor: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Parent's family doctor: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Child's Allergies: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medicines child is taking: \_\_\_\_\_

\_\_\_\_\_

Other pertinent past medical history: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Parent