

**AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT  
& EMERGENCY CONTACT INFORMATION**

Crystal Lake Babe Ruth Baseball League, Inc. & Crystal Lake Park District

As a parent and/or guardian, I do herewith authorize the treatment by a qualified and licensed medical doctor of the following minor in the event of a medical emergency which, in the opinion of the attending physician may endanger his or her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

**Name of Minor:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

Date(s) when release is intended: 2012 Crystal Lake Babe Ruth Baseball Season

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

Home Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Father's Cell #: \_\_\_\_\_ Father's Work #: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Mother Cell #: \_\_\_\_\_ Mother's Work #: \_\_\_\_\_

In case of emergency, please contact: Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

Physician to be called in an emergency: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist to be called in an emergency: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital of choice: \_\_\_\_\_

Special Information (development concerns, habits, allergies, medical attention, medications, etc.):

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**This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.**

IF REGISTERING VIA FAX, YOUR FACSIMILE SIGNATURE SHALL SUBSTITUTE FOR AND HAVE THE SAME LEGAL EFFECT AS AN ORIGINAL FORM SIGNATURE.

\_\_\_\_\_  
Signed (Parent/Legal Guardian)

\_\_\_\_\_  
Date

**LEAGUE USE ONLY:**

Prep \_\_\_\_\_ Major \_\_\_\_\_ Senior \_\_\_\_\_ Regis # \_\_\_\_\_ Team \_\_\_\_\_