



## Medical Information

### CONSENT TO TREAT

This is to certify that on this date, I \_\_\_\_\_, as a parent or guardian of (athlete participant), or for myself as an adult participant, give my consent to RAYBA to obtain medical care from any licensed physician, hospital, or clinic for the above mentioned participant, for any injury that could arise from participation in RAYBA sanctioned events.

If said participant is covered by any insurance company, please complete the following.

Name of Insurance Company: \_\_\_\_\_

Policy Number \_\_\_\_\_

Signed: \_\_\_\_\_

(Parent/guardian or adult participant)

Relationship to Athlete: \_\_\_\_\_

Home

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

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

### In case of Emergency Contact:

Name: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Physician's Name \_\_\_\_\_

Are you currently taking any medications? \_\_\_\_\_ -What Why? \_\_\_\_\_

Has the doctor placed any restrictions on your activity? \_\_\_\_\_ Explain \_\_\_\_\_

Please list any medical conditions that should be known: \_\_\_\_\_

\_\_\_\_\_