

CONSENT TO TREAT FORM

This is to give _____
(Name of coach)
consent to sign for emergency medical and/or surgical treatment for the following named
person: _____

Please list:

Allergies: _____

Last Tetanus: _____

Medications: _____

Family Physician: _____

Phone #: _____

Dentist: _____

Phone #: _____

Preferred Surgeon: _____

Phone #: _____

Responsible Party's Name: _____

Phone #: _____

Signature: _____

Date: _____

Social Security #: _____

Insurance Company: _____

Policy #: _____

This consent to treat form is valid for six months after above date.