

**N.W.D.A.S.A.
YOUTH
LEAGUE**

(PLEASE PRINT)

Child's Name _____
Child's Birth Date _____
Child's School _____ **Grade** _____
Child's Address _____
Child's Phone _____
Parent's Name _____

Parent's Work _____

Parent's Cell _____

CONSENT FOR MEDICAL CARE OF A MINOR

I _____, the parent and or legal guardian of _____, a minor, do hereby authorize _____ to sign all required documents authorizing a physician, surgeon, or dentist to exercise his/her professional judgment and to assess the risks incidents to and choose the necessary treatment from any available alternatives and to render such care and perform such treatment as he/she in his/her professional judgment determines to be necessary for the health or safety of the above named minor.

Signature of parent/guardian _____ **Date** _____
Address _____ **City** _____ **Zip** _____
Phone Home _____ **Work** _____ **Cell** _____

Treatment Information:

Minors birth date _____ **Date of last Tetanus** _____
Minors Physician _____ **Phone** _____
Allergies _____
Medication now taking _____
Minor's medical history _____

