

Michigan Storm Softball, LLC
MEDICAL CONSENT



Legal Name of player (must match birth certificate):

Last _____ First _____ Date of Birth _____

Address _____ City: _____ State: _____ Zip: _____

Phone # _____ School _____

Father/Guardian _____ Cell # _____

Employer _____ Work # _____

Mother/Guardian _____ Cell # _____

Employer _____ Work # _____

Name of Primary Medical Insurance Company: _____

Policy/Contract number: _____ Group number of the policy: _____

PARTICIPANT MEDICAL HISTORY (please circle)

- | | | |
|---|-----|----|
| 1. Are there any past surgeries or scheduled surgeries? | Yes | No |
| 2. Does the participant have any allergies (penicillin, bee stings, etc)? | Yes | No |
| 3. Does the participant have asthma/require the use of an inhaler? | Yes | No |
| 4. Is the participant diabetic/require medication for diabetes? | Yes | No |
| 5. Does/has the participant have/had seizures? | Yes | No |
| 6. Does the participant wear a brace or other medical support device? | Yes | No |

If you answered yes to any of the above questions, please provide the question number and an explanation in the following space to assist your coach with any medical concerns:

FITNESS TO PARTICIPATE

Participation in softball may subject me to physical exertion. I hereby state that (unless I have informed Michigan Storm Softball otherwise in writing) I am physically fit to participate in this activity. I have also provided Michigan Storm Softball or team coach with written information regarding any health or medical conditions I have, including prescriptions, and consent to this information being disclosed to any health care provider in connection with any treatment I receive.

EMERGENCY AUTHORIZATION

I, the undersigned, parent or legal guardian of the participant, a minor, hereby authorize the coaches, board members, or parents of team members acting in the capacity of activity supervisors and mentors to consent to medical, surgical or dental examination and/or treatment in the event that the parent cannot be contacted and hereby assume the expenses of such care.

PLAYERS SIGNATURE

STORM TEAM NAME/AGE GROUP

DATE

PARENT SIGNATURE

PARENT SIGNATURE

DATE

If there is an emergency and I am unreachable, the following individual is hereby authorized to act on my behalf.

NAME

RELATIONSHIP TO PLAYER

CELL #