WALPOLE YOUTH BASEBALL FOUNDATION
2025
Emergency Medical Treatment Form

In the event of an emergency requiring medical attention, I hereby grant permission to a physician or other hospital personnel (collectively "Hospital Personnel") to attend my child, _____ ("Child"). My Child may be in the care of an authorized representative from the Walpole Youth Baseball Foundation (the "Foundation"). I have authorized such representatives to make decisions regarding the care of my Child. I authorize Hospital Personnel to follow the instructions of the Foundation's representatives regarding the care of my Child until I am present at the medical center.

Child:
Name of Child: _____ Date of Birth: _____ Grade: ___ Age:___

Parent/Guardian
Parent/Guardian: _____
Home #: _____ Work #: _____

Parent/Guardian: _____
Home #: _____ Work #: _____

Email address to be used by the coach: _____

If unable to contact the above person(s), please notify:

Name: _____
Home #: _____ Work #: _____

Name: _____
Home #: _____ Work #: _____

List any medical problems or conditions that your child has, such as asthma, heart trouble, diabetes, epilepsy, allergies, etc.

_____
_____
_____

Insurance

Provider:_____ Group Number: _____

_____ _____
Signature of Parent or Legal Guardian Date

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