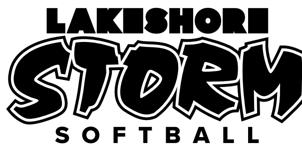


# 2020-2021 MEDICAL CONSENT FORM

www.lsstorm.com

*Legal Name of player (must match birth certificate):*

**Last** ____________________________ **First**____________________________ **Date of Birth**_____________________

Address: _________________________________ Height __________Weight__________ School________________________

City: ______________________________ State: ________ Zip:____________ Phone #__________________________

Name of Primary Medical Insurance Company: _______________________________________________________

Policy/Contract number:______________________________ Group number of the policy:____________________

**Father/Guardian**____________________________________________ Home phone ___________________________

Employer________________________________ Work # _______________________ Cell #______________________

**Mother/Guardian**____________________________________________ Home phone____________________________

Employer________________________________ Work # _______________________ Cell #______________________

**PARTICIPANT MEDICAL HISTORY**

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 the softball and baseball program may subject me to physical exertion, I hereby state that (unless I have informed the Lakeshore Storm Softball and Baseball Club otherwise in writing) I am physically fit to participate in this activity. I have also provided the Lakeshore Storm Softball and Baseball Club 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, herby 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.

Parent/Guardian Signature ____________________________________________ Date____________________

Player Signature_____________________________________________________ Date____________________

**If there is an emergency and I am unreachable, please contact the individual below who is herby authorized to act on my behalf.**

Name_________________________________________________ Relationship to player_________________________

Address______________________________________________________________________________________