



WBF EMERGENCY MEDICAL FORM

In the event my son/daughter becomes ill or is injured while participating in any WBF Junior Federation event, I hereby give my consent to the WBF Officials or their designees, it's board members and officers to authorize the administration of any emergency medical or dental treatment deemed necessary by a licensed physician or dentist, and the transfer of the child to a hospital, clinic or office to obtain treatment. It is understood that reasonable attempts will be made to contact the parents or guardian at the number listed below prior to administration if reasonably possible. The following questions will help us to be prepared for your child.

1. Any allergies including food, insect bites and medications? Please list.
2. What signs or symptoms result with the allergy (i.e. difficulty breathing, hives, rash etc)?
3. What is the usual method of treatment when allergy occurs?
4. Does the youth have any medical conditions we should know about currently? Please list.
5. Does the youth currently take medication for the above named condition? If so, please list including name of medication (i.e. twice a day, three times a day)
6. Does the youth have any physical limitations we should know about?

Please Print:

Parent or Legal Guardian Name _____ Phone _____

_____ I give my consent for the above emergency treatment

_____ I DO NOT give my consent for the above emergency treatment

Signature _____ Date _____