



A Non-Profit Corporation

## 2010 Player Medical Treatment Form

Player: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ DOB: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Mother's cell: \_\_\_\_\_ Father's cell: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Family Medical Insurance: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Date / Last Physical: \_\_\_\_\_

Do you have a history of diabetes or epilepsy? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, explain: \_\_\_\_\_

List Medications you are allergic to: \_\_\_\_\_

I, \_\_\_\_\_, give permission to administer anesthetic and /  
or treatment as deemed required by the attending physician.

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Notary Signature

\_\_\_\_\_  
Date

Please complete this form and either email it to [allamericanprospects@yahoo.com](mailto:allamericanprospects@yahoo.com) or mail it to the address listed below:

**All American Prospects Baseball, Inc.**

c/o David Parra  
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