

Delaware Valley Athletic Association

P.O. Box 491, Milford, NJ 08848 * www.leaguelineup.com/delvalaa

CONSENT FOR TREATMENT

Name of Player: _____ Player's Age: _____

Home Address: _____ City: _____ State: _____

Family Physician: _____ Phone: _____

List any Allergies: _____

Required Medication(s): _____

Name of Team: _____

Team Accident Insurance Company: _____

Team Accident Insurance Policy No.: _____

In case of accident or illness, I hereby authorize a representative of the Delaware Valley Athletic Association, Inc. (DVAA) to use his/ her judgment in obtaining immediate medical care.

Date: _____ Signed: _____
(Parent or Guardian)

Daytime Phone: _____ Home Phone: _____

Parents will be notified in case of serious illness or injury as quickly as they can be reached, but this will make immediate treatment possible.