



Brandon Broncos Youth Football Inc.

P.O. Box 2001
Brandon, FL 33509
www.brandonbroncos.org

Medical Treatment Authorization Form

Child Name: _____ DOB: _____

In the event of an emergency occurring while my son/daughter is at practice, game, or competition, I grant my permission to the Brandon Broncos volunteers to take whatever action necessary. In the event that I cannot be reached, I hereby authorize the Brandon Bronco's volunteers to give consent for my son/daughter to receive medical treatment.

Parent/Guardian Names: _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Mom Cell _____ Dad Cell _____

Person to be notified (other than parent/guardian) in case of emergency:

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Insurance Company: _____ Group #: _____

Policy #: _____ Insurance phone: _____

Medical Information

Heart Disease	Yes	No	Asthma	Yes	No	Diabetes	Yes	No
Allergic to Medication	Yes	No	Convulsions	Yes	No	Sickle Cell Anemia	Yes	No
Environmental/Insect Allergies	Yes	No	Food Allergies	Yes	No	Current Medications	Yes	No

If yes to any above please describe treatment to be provided. (I.e. rescue inhaler for asthma, orange juice/candy bar for diabetes, etc...)

Parent Signature _____

Date _____