

## Medical Treatment Authorization Form

This form grants temporary authority to a designated adult to provide and arrange for medical care for a minor in the event of an emergency, where the minor is not accompanied by either parents or legal guardians, and it may not be feasible or practical to contact them. This form should be given to the Baldwinsville Youth Wrestling Coach's and will be carried by them for the duration of the program.

### Minor

Full Legal Name: \_\_\_\_\_

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

Date of Birth: \_\_\_\_\_ Gender: Female \_\_\_\_\_ Male \_\_\_\_\_

### Information for Medical Treatment

Physician's Name and Location of Practice: \_\_\_\_\_

Physician's Phone # (if known): ( \_\_\_\_ ) \_\_\_\_\_

Medical Insurer/Health Plan: \_\_\_\_\_ Policy #: \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

Allergies (Other): \_\_\_\_\_

Please note **all** conditions for which the child is currently receiving treatment:

\_\_\_\_\_  
Note any other significant medical information:

### AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

I do hereby state that I have legal custody of the aforementioned Minor. I grant my authorization and consent for Pat Blackford or Gene Lang or Jim Weber or Brett Barrie or Justin Farrar or Anthony Fiorini Corey Anthony or Justin Kapr or Dave Gillespie or Dan Hunt or Chris Horning or Alex Hayes or Brett Cataldi or Jim Schanzenbach or Todd Webb or Tony Burkinshaw or Gabe Bouthillier (hereafter "Designated Adults") to administer general first aid treatment for any minor injuries or illnesses experienced by the Minor. If the injury or illness is life threatening or in need of emergency treatment, I authorize the Designated Adults to summon any and all professional emergency personnel to attend, transport, and treat the minor and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur. I agree to assume financial responsibility for all expenses of such care.

It is understood that this authorization is given in advance of any such medical treatment but is given to provide authority and power on the part of the Designated Adults in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

This authorization is effective through May 1, 2026. Signed this \_\_\_\_ day of \_\_\_\_\_ 2025.

Parent / Legal Guardian Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_