RBI Program Application and Medical Consent Form

Baseball _____

Softball _____
LEAGUE NAME

PLAYER INFORMATION

Name
_____
(last) (first) (M.I.)

Permanent Address:_____ City_____ State_____ Zip_____

School_____ HS Graduation Year_____ Birthdate _____

Country of Origin _____ How long have you lived in the United States? _____ (years)

Ethnic Origin: Asian Black Latino Native American White Other _____

Name of Parent(s), Spouse, or Guardian (circle one) _____

Address _____
(no.) (street) (city) (state) (zip) (country)

Telephone: Work (_____) _____ Home (_____) _____ Cell (_____) _____

IN CASE OF EMERGENCY, CONTACT THE FOLLOWING INDIVIDUAL IF THE PERSON ABOVE CANNOT BE REACHED:

Name_____ Relationship _____

Address _____
(no.) (street) (city) (state) (zip) (country)

Telephone: Work (_____) _____ Home (_____) _____ Cell (_____) _____

Name of Physician or Clinic that you usually consult for medical care: _____

Address _____ Phone (____) _____
(no.) (street) (city) (state) (zip)

INSURANCE INFORMATION

Health Insurance Company Name_____

Address_____ City_____ State_____ Zip_____ Telephone( )_____

Policy Number _____ Subscriber Name _____ Subscriber Social Security # _____- _____-_____

PERMISSION FOR TREATMENT IN CASE OF IMMEDIATE NEED

If your son/daughter is a minor (under 18 years of age), you as a parent or legal guardian must sign this consent form so that the RBI Program can provide appropriate diagnosis and treatment and emergency health service procedures may be promptly carried out with no unnecessary delay. Without a signed permission for treatment, your minor son/daughter cannot receive treatment unless his/her presenting condition is exempted from requiring parental consent and/or notification. Even with a signed permission for treatment, we will attempt to contact and fully inform you as parent legal guardian before performing any major diagnostic/treatment procedure except in an emergency. It should be understood that under certain circumstances your son/daughter will be transported for diagnosis and treatment.

I certify that the foregoing information is true and complete to the best of my knowledge. I give my permission to the RBI Program to furnish such diagnostic, therapeutic, voluntary immunization, and/or operative procedures and/or transportation as may be deemed necessary by the RBI Program for my son/daughter who is under the age of 18 years. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as the result of treatment or examination. I further acknowledge that the terms of the RBI program player release & waiver (including, without limitation, the section titled RELEASE FROM LIABILITY AND COVENANT NOT TO SUE) are hereby incorporated by reference.

_____ _____ _____
Signature of Parent/Guardian Name of Parent/Guardian (please print) Date

_____ _____

Signature of Player Date