

Columbus Lady Rage  
CONSENT TO TREAT FORM

**Athlete Info:**

Athlete Name: \_\_\_\_\_

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

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

Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Allergies: \_\_\_\_\_

Last Tetanus: \_\_\_\_\_

Medications: \_\_\_\_\_

Family Physician: \_\_\_\_\_

Phone #: \_\_\_\_\_

Dentist: \_\_\_\_\_

Phone #: \_\_\_\_\_

Preferred Surgeon: \_\_\_\_\_

Phone #: \_\_\_\_\_

**As the parent/legal guardian of a minor, I give my consent for emergency treatment after evaluation by a physician, if reasonable attempts to contact me have been unsuccessful.**

**Responsible Party's Information:**

Name: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy #: \_\_\_\_\_

**Second Emergency Contact Information (Someone other than Parents/Guardians):**

Name: \_\_\_\_\_

Phone #1: \_\_\_\_\_ Phone #2: \_\_\_\_\_

Relationship to Athlete: \_\_\_\_\_

**This consent to treat form is valid for one year from the date of signature.**