

PALM BEACH COUNTY U-19 RUGBY CLUB

Medical Consent

I _____, the parent/guardian of _____, acknowledge that my child/ward is a member of the Palm Beach County U-19 Rugby Club, and a participant in Palm Beach County U-19 Rugby Club events. I do hereby consent to any and all emergency medical and/or surgical treatment which may be advisable by the physicians and/or surgeons of my child/ward. The intention herein is to grant authority to administer and perform all and any examinations, treatments, anesthetics, operations and diagnostic procedures, which may be deemed advisable or necessary. I further hereby authorize the use or disclosure of the individually identifiable health information of my child/ward should treatment for illness or injury become necessary. I also agree that my child/ward, when admitted for treatment, is to remain in the hospital until his/her physician recommends that the patient is discharged.

Please check if appropriate and supply requested information:

_____ My child/ward is covered under our family health insurance plan which has limits of not less than \$100,000.

Company: _____ Policy Number _____

Signature of Parent/Guardian

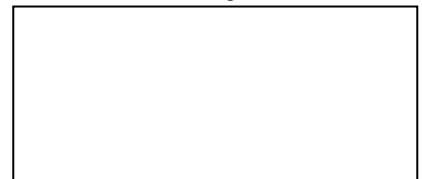
Printed Name of Parent/Guardian

Date

STATE OF FLORIDA, COUNTY OF PALM BEACH

Sworn to and subscribed before me this _____ day of _____ of _____.
month year

Stamp



NOTARY PUBLIC; State of Florida at Large My commission expires: _____