

# East Cobb Braves

## I. CONSENT

I (We), the parent(s) or legal guardian(s) of, a minor, \_\_\_\_\_ in consideration of the agreement by the East Cobb Braves Baseball Team ("Braves") to permit my (our) child to participate in team related activities or trips, to take place September 1, 2009 to December 31, 2010, do indemnify, protect and hold harmless the Braves, its staff, coaches, volunteers, and all private persons or organizations volunteering services without charge to supervise or chaperone my (our) child while on any trips or activities from any claim or liability whatsoever, including, but not limited to, personal injury, property damage, court costs, attorneys' fees and interest, however caused, as a result of my (our) child participating in the trip or activity.

I (We) do further agree that the Braves, its coaches and staff, reserve the right to terminate the participation of the above child for failure to behave and act in accordance with the Braves regulations on conduct, for failure to follow the instructions or directions of the coaches, or for any acts of conduct of the above child deemed by said coaches and staff, to be detrimental to or incompatible with the interest, harmony, comfort or welfare of the trip or activity as a whole. If the participation of the above child is terminated, only the funds not actually used will be refunded, and the child will be sent home at my (our) expense.

## II. LIMITED POWER OF ATTORNEY

If I (We) cannot be immediately contacted, we grant full power of attorney to the official representative or chaperone in the event of accident or illness of the above child at any time from the commencement to the termination of the activity or trip, to do as follows:

1. To arrange for the transportation of my child, whether by ambulance or otherwise, to a proper facility where emergency medical treatment would normally be administered, including, but not limited to, an emergency room of a hospital, a doctor's office, or a medical clinic, and
2. To sign any releases as may be required in order to obtain any medical or surgical treatment as is required in the judgment of medical authorities at the facility.
3. To do and perform every act necessary and proper to be done in the exercise of any of the foregoing powers as fully as I (we) might or could do if personally present, with full power of substitution and revocation hereby ratifying and confining all that my (our) said attorney(s) shall lawfully do or cause to be done by virtue hereof.
4. I (we) further aver that I (we) have disclosed all known medical conditions, allergies, hypersensitivity's, illnesses (chronic or otherwise) and other medical information to my (our) said attorney(s) pertaining to said child.

\_\_\_\_\_  
Parent/Legal Guardian

\_\_\_\_\_  
Parent/Legal Guardian

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

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

\_\_\_\_\_  
Telephone: \_\_\_\_\_

\_\_\_\_\_  
Telephone: \_\_\_\_\_

Notary Signature and Expiration: \_\_\_\_\_

# Medical Information

Child's Name \_\_\_\_\_ Birthday \_\_\_\_\_

Parent/guardian Name \_\_\_\_\_

Home address \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Other phone \_\_\_\_\_

If not available in an emergency, notify:

Name \_\_\_\_\_ Phone \_\_\_\_\_

List Allergies: (Drugs, insect stings, poison ivy, hay fever, other)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does this Participant have any medical or health problems, and has this child had any chronic or recurring illness or illnesses which would have an effect on his/her's participation in any trip, activity or sport?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe \_\_\_\_\_

\_\_\_\_\_

Date of last tetanus shot \_\_\_\_\_

Medications your child takes regularly \_\_\_\_\_

Instructions for this medication \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ My child may self-administer \_\_\_\_\_ Please adult administer

Please check the over the counter medications that may be administered to your child:

Tylenol \_\_\_\_\_, Advil \_\_\_\_\_, Tums \_\_\_\_\_, Emetrol \_\_\_\_\_, Benedryl \_\_\_\_\_, Immodium \_\_\_\_\_, Cortisone \_\_\_\_\_  
Cream \_\_\_\_\_, Triple Antibiotic Ointment \_\_\_\_\_, Cough Drops \_\_\_\_\_, Sudafed \_\_\_\_\_, Other (describe) \_\_\_\_\_

\_\_\_\_\_

Physician who should be consulted in the event of emergency or medical problems involving this child:

Physicians Name \_\_\_\_\_ Medical Specialty \_\_\_\_\_

Physicians Phone \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Policy Holder \_\_\_\_\_

Policy Number \_\_\_\_\_ Ins. Co. phone number \_\_\_\_\_