

# South Sound Baseball

*Limited Power of Attorney for emergency medical care authorization*

Child's Name \_\_\_\_\_  
Last Name First Name Middle Initial

This is to certify that the bearer of this letter has permission of the undersigned to authorize necessary medical care by the attending physician, or others he/she may choose, in case of accidental injury, ingestion, or illness:

The undersigned accepts all financial responsibility for necessary treatment and services.

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Insurance \_\_\_\_\_ Policy / Membership # \_\_\_\_\_

Employer \_\_\_\_\_ Group / Plan # \_\_\_\_\_

Blood Type (Child's) \_\_\_\_\_ Allergies \_\_\_\_\_

Other medical conditions \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship \_\_\_\_\_