

LEAGUE OF INDEPENDENT SPORTS TEAMS

CONSENT FOR MEDICAL TREATMENT

As the parent/legal guardian of _____ who is participating in the _____ program listed above, I hereby give my consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve the life, limb or well being of _____.

Date _____

Name _____ (Please Print)

Signature _____