eliminating racism
empowering women
ywca

POWER TO AUTHORIZE MEDICAL TREATMENT

I, the undersigned, as and/or legal guardian of_____ ("my child") do recognize that medical treatment may become necessary during my child's participation with the YWCA Field Hockey Program or during practices prior to and to avoid delay of any necessary medical treatment and/or that which would alleviate physical discomfort attendant to physical injury, HEREBY EMPOWER the coaches and/or organizers of the YWCA Field Hockey Program or other designated persons to authorize on my behalf recommended medical treatment of my child by any staff member of any hospital, medical doctor, emergency medical technicians and/or other paramedic.

This AUTHORIZATION is complete in and of itself and is fully operative upon my signature for the duration of my child's participation with the YWCA Field Hockey Program. I agree not to seek damages or take action against the physician or health care facility for treatment rendered on an emergency basis and hold harmless those owners private or public of facilities at which practices or meetings for the Team might be held (including but not restricted to the YWCA of Westmoreland County) but request that I be contacted at the earliest convenience.

Dated this_____day of_____, 20___

_____

Parent Signature