



All Stars Emergency Card & Authorized Pick Up

Child(s) Last Name, First Name

1.			
Parent/Guardian	Home	Cell	Work
2.			
Parent/Guardian	Home	Cell	Work
3.			
Other/Relationship	Home	Cell	Work
4.			
Other/Relationship	Home	Cell	Work
5.			
Other/Relationship	Home	Cell	Work

If I can not be reached, I give permission for emergency treatment, hospitalization, anesthesia or injection and will be responsible for the bills of the same. My authorization does not cover major surgery unless the medical opinion of two licensed physicians or dentists concurring the treatment are obtained prior to the performance of such treatment.

Signature of parent/guardian

Date

Signature of parent/guardian

Date



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