

**RBI Program Application and Medical Consent Form**

Baseball \_\_\_\_\_

Softball \_\_\_\_\_

LEAGUE NAME

**PLAYER INFORMATION**

Name

\_\_\_\_\_ (last) \_\_\_\_\_ (first) \_\_\_\_\_ (M.I.)

Permanent Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

School \_\_\_\_\_ HS Graduation Year \_\_\_\_\_ Birthdate \_\_\_\_\_

Country of Origin \_\_\_\_\_ How long have you lived in the United States? \_\_\_\_\_ (years)

Ethnic Origin: Asian Black Latino Native American White Other \_\_\_\_\_

Name of Parent(s), Spouse, or Guardian (circle one) \_\_\_\_\_

Address \_\_\_\_\_ (no.) \_\_\_\_\_ (street) \_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip) \_\_\_\_\_ (country)

Telephone: Work (\_\_\_\_\_) \_\_\_\_\_ Home (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT THE FOLLOWING INDIVIDUAL IF THE PERSON ABOVE CANNOT BE REACHED:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ (no.) \_\_\_\_\_ (street) \_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip) \_\_\_\_\_ (country)

Telephone: Work (\_\_\_\_\_) \_\_\_\_\_ Home (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_

Name of Physician or Clinic that you usually consult for medical care: \_\_\_\_\_

Address \_\_\_\_\_ (no.) \_\_\_\_\_ (street) \_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip) Phone (\_\_\_\_\_) \_\_\_\_\_

**INSURANCE INFORMATION**

Health Insurance Company Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone( ) \_\_\_\_\_

Policy Number \_\_\_\_\_ Subscriber Name \_\_\_\_\_ Subscriber Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**PERMISSION FOR TREATMENT IN CASE OF IMMEDIATE NEED**

*If your son/ daughter is a minor (under 18 years of age), you as a parent or legal guardian must sign this consent form so that the RBI Program can provide appropriate diagnosis and treatment and emergency health service procedures may be promptly carried out with no unnecessary delay. Without a signed permission for treatment, your minor son/ daughter cannot receive treatment unless his/ her presenting condition is exempted from requiring parental consent and/ or notification. Even with a signed permission for treatment, we will attempt to contact and fully inform you as parent legal guardian before performing any major diagnostic/ treatment procedure except in an emergency. It should be understood that under certain circumstances your son/ daughter will be transported for diagnosis and treatment.*

I certify that the foregoing information is true and complete to the best of my knowledge. I give my permission to the RBI Program to furnish such diagnostic, therapeutic, voluntary immunization, and/or operative procedures and/or transportation as may be deemed necessary by the RBI Program for my son/daughter who is under the age of 18 years. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as the result of treatment or examination. I further acknowledge that the terms of the RBI program player release & waiver (including, without limitation, the section titled RELEASE FROM LIABILITY AND COVENANT NOT TO SUE) are hereby incorporated by reference.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Name of Parent/Guardian (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Player

\_\_\_\_\_  
Date