- - - EMERGENCY MEDICAL AUTHORIZATION - - -

Purpose: To enable parents or guardians to authorize the provision of emergency treatment for players who become ill or injured while under coaches authority when parents or guardians cannot be reached. THIS FORM MUST BE FILLED OUT IN INK EACH SCHOOL YEAR!

Player's Name_____ Sport_____ Grade_____

Adddress_____
(Street) (City) (State) (Zip)

Phone_____Birthday_____

Father_____
(Name) (Employer) (Phone)

Mother_____
(Name) (Employer) (Phone)

Guardian_____
(Name) (Employer) (Phone)

Dependable relative or neighbor to call in an emergency (illness or injury)
When parent or guardian cannot be reached _____
(Name) (Phone)

Allergies _____ Date of last tetanus shot _____

Medication being taken _____
(Name) (Dosage) (Time(s) Taken)

List of health problems. For example: asthma, vision, epilepsy, diabetes, hearing, bone or muscle problems, etc. _____

Medical Insurance Firm_____ Policy #_____

PART I OR II MUST BE COMPLETED

Part I – To Grant Consent: If unable to reach parent or guardians, I hereby give my consent for 1) the administration of any treatment deemed necessary by _____ or
(Physician)
_____ in the event that the designated practitioner is not available another
(Dentist)
licensed physician or dentist and 2) the transfer of the player to _____
or any other hospital reasonably accessible. (Hospital)

This authorization does not cover surgery unless the medical opinions of two other licensed physicians or dentists concurring in the surgery are obtained prior to the performance of such surgery.

_____
(Date) (Signature of Parent of Guardian)

Part II – Refusal to Consent: I **DO NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish team authorities to take no action or to: _____

_____
(Date) (Signature of Parent or Guardian)