

Sport \_\_\_\_\_

Coach \_\_\_\_\_

---

## EMERGENCY MEDICAL AUTHORIZATION TYRONE AREA HIGH SCHOOL ATHLETICS

PLEASE PRINT

Date: \_\_\_\_\_

Athlete's Name \_\_\_\_\_ Parent's Name \_\_\_\_\_

Birth Date \_\_\_\_\_ Address \_\_\_\_\_

Age \_\_\_\_\_ Phone No \_\_\_\_\_

Grade \_\_\_\_\_ Office/Work/Other Phone No \_\_\_\_\_

Phone No \_\_\_\_\_ Family Physician \_\_\_\_\_

Date of last TETANUS shot \_\_\_\_\_

Allergies \_\_\_\_\_

Blood Type \_\_\_\_\_

Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, X-ray examination and immunizations for the above named athlete. In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, the treatment necessary for the best interest of the above named athlete may be given.

In the event that an emergency arises during a practice session, or event, an effort will be made to contact the parents of guardians as soon as possible. Permission is also granted to the athletic trainer, coach or team physicians to provide the needed emergency treatment to the athlete prior to his admission to the medical facilities.

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

Signature of Witness \_\_\_\_\_

Date \_\_\_\_\_