

---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!

Last Name _____ First Name _____

Street Address _____ City: _____ State: _____ Zip: _____

Home Phone _____ Grade _____ Date of Birth _____

Parish _____ Sport _____

Mother's Name/cell phone/email: _____

Father's Name/cell phone/email: _____

Guardian's Name/cell phone/email: _____

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. 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 guardian, I hereby give my consent for 1) the administration of any treatment deemed necessary by _____ (physician) or _____ (dentist) in the event that the designated practitioner is not available another licensed physician or dentist and 2) the transfer of the player to _____ (hospital) or any hospital reasonably accessible.

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.

(Parent or guardian's signature & date signed)

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:

(Parent or guardian's signature & date signed)