---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)