

Emergency Medical Authorization

Purpose: For parents/guardians to authorize emergency treatment to children who become ill or injured while under school authority, when parents cannot be reached.

For: _____

Name of Athlete _____

Address _____

City/State/Zip _____

Phone _____

Name of School _____

Parent/Guardian _____

Work Telephone # _____

In the event reasonable attempts to contact me _____ (parent/guardian) are unsuccessful, I (We) the undersigned parent/legal guardian of _____, do authorize any hospital, clinic, or licensed physician to treat my/our child and administer any x-ray examination, anesthetic, or surgical diagnosis rendered under the general or special supervision of any member of the medical staff of the hospital, clinic, or office.

Our preferred physician is _____ whose phone number is _____. Our preferred dentist is _____ whose phone number is _____. Our preferred hospital is _____.

In the event the designated preferred practitioner is not available, we authorize in advance another licensed physician or dentist the authority and power to render care in his/her best judgement and the transfer of the child to any hospital reasonably accessible. It is also understood that every effort shall be made to contact the parent/legal guardian prior to rendering treatment to the patient, but that treatment will not be withheld if the parent/guardian cannot be contacted. Permission is also granted for the school's athletic trainer or coach to provide emergency treatment to my/our child prior to his/her admission to any medical facility.

Signature of Parent/Guardian

Date _____

List of restrictions/physical impairments:

List of special medications taken by child: