EMERGENCY MEDICAL FOR ATHLETES - PLEASE FILL OUT FRONT AND BACK

____ Please check if your address or phone number has changed

5341 F1

Emergency Medical Authorization

Student Name _____ Date of Birth _____

Address_____ Phone _____

School_____ Grade_____ Homeroom_____ Bus No._____

Purpose – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Mother _____ Home #_____Work #_____ Cell #_____

Father _____ Home #_____ Work #_____ Cell #_____

Guardian_____ Home #_____Work #_____ Cell #_____

Stepparent_____ Home #_____Work #_____ Cell #_____

If my child becomes ill at school and attempts to contact me have been unsuccessful, I authorize the school to call the following persons who are authorized to pick up my child:

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

PART I OR II MUST BE COMPLETED

PART I – TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor_____ Phone_____ Dentist_____ Phone_____

Preferred Hospital_____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two (2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted: _____

_____

Date_____ Signature of Parent/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 the school authorities to take the following action:

_____

_____

Date_____ Signature of Parent/Guardian_____

REQUEST FOR WAIVER OF INSURANCE PLAN COVERAGE

To Whom It May Concern:

I understand that my child cannot participate in boys' or girls' after school athletics unless he or she is covered by the School Accident Coverage Plan.

I have adequate insurance for my child, _____, and do not wish to enroll in the school coverage plan. I accept full responsibility for the cost of treatment for any injury which they may suffer while taking part in the program.

Please waive this requirement and permit him or her to take part in athletics.

Parent's Signature _____

Date _____