## --- 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!

Player's Name	Sport	Grade
Adddress		
(Street) Phone	(City) (State)Birthday	(Zip)
Father(Name)		
(Name)  Mother	(Employer)	(Phone)
(Name) Guardian	(Employer)	(Phone)
(Name)	(Employer)	(Phone)
	or to call in an emergency (illness to be reached	
Allergies	(Name) Date of last tetanus sho	(Phone)
List of health problems. For e	Name) (Dosage) example: asthma, vision, epilepsy, dia	(Time(s) Taken) abetes, hearing, bone or
Medical Insurance Firm	Pol	licy #
PA	RT I OR II MUST BE COMPLET	<u>ED</u>
Part I – To Grant Consent:	If unable to reach parent or guardians	, I hereby give my consent for
	eatment deemed necessary by	
	e event that the designated practitione	
(Dentist) licensed physician or dentist a	nd 2) the transfer of the player to	
or any other hospital reasonab		(Hospital)
	over surgery unless the medical opinioning in the surgery are obtained prior to	
(Date)	(Signature of Parent of Guardian)	
	: I DO NOT give my consent for eress or injury requiring emergency treat	
(Date)	(Signature of Parent or Guardian)	