Emergency Medical Authorization

PLAYER NAME _____

ADDRESS _____

TELEPHONE _____

SCHOOL _____ **GRADE** _____

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

Part I or II must be completed
PART I - TO GRANT CONSENT

In the event reasonable attempts to contact me at _____ (phone number) or _____ (other parent or guardian) at _____ (phone number) have been unsuccessful, I hereby give my consent for: (1) The administration of any treatment deemed necessary by Dr. _____ (preferred physician) or Dr. _____ (preferred dentist)., 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 _____ (preferred hospital) or any hospital reasonably accessible.

_____

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring on 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 or Guardian** _____

Do not complete Part II if you completed Part I
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 coach to take no action or to: _____
_____
_____

Date _____ **Signature of Parent or Guardian** _____

Address _____

Medical Insurance Company _____ **Policy #** _____