

2010-2011 MEDICAL EMERGENCY INFORMATION

Student Name _____ Date of Birth ____ / ____ / ____ Cell Phone _____
Home Address _____ Home Phone _____
Person to Call in Case of Injury _____ Relationship _____ Contact # _____
Medications in Use _____ Medicine Allergies _____
Family Doctor _____ Doctor's Phone Number _____
Doctor's Office Address _____
Preferred Hospital for Emergency Treatment _____

MEDICAL EMERGENCY AUTHORIZATION

Name of Student Athlete _____ School _____ Grade _____
Last First Middle

As parent or legal guardian, I authorize the team physician or in his/her absence, a qualified physician to examine the above-named student and in the event of injury, to administer emergency care and to arrange for any consultation he/she deems necessary to ensure proper care of any injury. Every effort will be made to contact parent/guardian to explain the nature of the problem prior to any involved treatment.

I understand that I will assume full responsibility for payment of any services rendered.

Signature of Parent/Guardian _____ **Date** _____