MEDICAL EMERGENCY AUTHORIZATION TO TREAT

Instructions: PLEASE PRINT! A photocopy of the front and back of your health insurance card should be attached to this form. Please turn in with all other forms on or before the first day of practice.

Athlete Name (first and last): _____

Medical Insurance Company: _____

Phone Number: _____ Policy Number: _____

Allergies: _____

Medications taken daily or routinely: _____

IN CASE OF EMERGENCY, THE PARENT/GUARDIAN PRIMARY CONTACT:

Parent #1: _____ Cell Phone: _____

Parent #2: _____ Cell Phone: _____

Other: _____ Cell Phone: _____

I HEREBY GIVE CONSENT FOR THE FOLLOWING LOCAL MEDICAL CARE PROVIDER AND LOCAL HOSPITAL TO BE CALLED FOR EMERGENCY TREATMENT:

Physician's Name: _____ Phone: _____

Dentist's Name: _____ Phone: _____

Hospital of Choice: _____ Phone: _____

IN THE EVENT THAT REASONABLE ATTEMPTS TO CONTACT A PARENTY/GUARDIAN HAVE BEEN UNSUCCESSFUL, I HEREBY GIVE MY CONSET FOR:

1. The administration of any treatment deemed necessary by the above named physician, dentist or by another licensed physician or dentist if the above named are unavailable.
2. The transfer of the athlete to any hospital reasonably accessible.

I UNDERSTAND THAT THIS AUTHORIZATION DOES NOT COVER MAJOR SURGERY UNLESS THE MEDICAL OPINIONS OF TWO LICENSED PHYSICIANS OR DENTISTS CONCURRING IN THE NECESSITY FOR SUCH SURGERY ARE OBTAINED PRIOR TO THE PERFORMANCE OF SUCH SURGERY.

Signature of Parent/Guardian: _____ Date: _____