MEDICAL EMERGENCY AUTHORIZATION FORM

TO BE COMPLETED BY PARENT AND RETURNED TO SCHOOL OFFICE

Name of Student Athlete ____

As Parent or Legal Guardian, I authorize the team physician or, in his 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 by a specialist, including a surgeon, he deems necessary to insure proper care of any injury. Every effort will be made to contact parent or guardian to explain the nature of the problem prior to any involved treatment.

Name__________________________________ Date ______________________
(Signature of Parent or Guardian)

Parent's Home Phone___________________________Business Phone __________________

Parent's Cell Phone____

Emergency Contact Person

Name__________________________________ Phone______________________

Relationship of contact person____

Family Physician's Name ____________________________ Phone____________________

Name of Family Insurance Company _______________________ Policy #________________

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FOR SCHOOL USE ONLY:

Completed Form Received ______________________
Date

Duplicate Copies Distributed as needed throughout the ______________________ school year.

Insurance coverage by parents Yes_____ No_____

School Insurance ________ Date Sent In_________ Coverage__________

One copy filed in Student Athletic Record:________________ By_________________

Date Name