MEDICAL EMERGENCY AUTHORIZATION TO TREAT

Instructions: Please print! It is recommended that a photocopy of the front and back of a health insurance card be attached to this form. This form must be turned in on the first day of practice.

Athlete Name (first middle last) ____

Medical Insurance Company ____

Phone Number _____________________________

Policy Number _____________________________

Allergies ____

Medications taken daily or routinely ____

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In case of an emergency, the parent/guardian primary contact should be:

Name __________________________ Contact number(s) _____________________________

Mother (first middle last) ____________________________________

Work Phone _________________ Cell Phone __________________ Email ______________________________

Father (first middle last) ____________________________________

Work Phone _________________ Cell Phone __________________ Email ______________________________

I hereby give consent for the following local medical care providers and local hospital to be called for emergency treatment:

Physician's Name ________________________

Phone Number ______________________________

Dentist's Name ________________________

Phone Number ______________________________

Local Hospital of Choice ____________________________ Contact Number ______________

In the event that reasonable attempts to contact a parent / guardian have been unsuccessful, I hereby give my consent for:

1. The administration of any treatment deemed necessary by the above named physician or dentist, or in the event that that physician or dentist is not available, by another licensed physician or dentist.
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 ________________