

# EMERGENCY MEDICAL AUTHORIZATION

PLAYER'S NAME: \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

TEAM \_\_\_\_\_ TELEPHONE(S) \_\_\_\_\_

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for players who become ill or injured while under the coach's authority, when parents or guardians cannot be reached.

## PART I OR PART II MUST BE COMPLETED

### PART I

In the event reasonable attempts to contact me at \_\_\_\_\_ (phone) or

\_\_\_\_\_ (other parent or guardian) at \_\_\_\_\_ (phone) have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by

Preferred Physician Dr. \_\_\_\_\_, phone at \_\_\_\_\_

Or preferred Dentist Dr. \_\_\_\_\_, phone at \_\_\_\_\_

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 \_\_\_\_\_ Hospital (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 in 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: \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE: X \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ ZIP \_\_\_\_\_

## DO NOT COMPLETE PART II IF YOU COMPLETE PART I

### PART II:

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 \_\_\_\_\_

SIGNATURE OF PARENT/GUARDIAN: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

ZIP \_\_\_\_\_