Authorization for Emergency Medical Care (Waiver)

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for student-athletes who become ill or injured while under school authority, when parents or guardians cannot be reasonably reached.

1. NAME (last) _____ (first) _____ (mi) _____ Grade _____ Date _____

ADDRESS (residence) _____ Sex _____ Age _____ Date of Birth _____

City _____ Zip _____ Phone _____ Social Security No._____

2. Father's Name_____ Phone _____ Employer_____ Phone_____

3. Mother's Name_____ Phone_____ Employer_____ Phone_____

4. Name and phone number of person(s), other than parent or guardian, who is authorized to approve emergency medical treatment:

   Name_____ Phone_____

5. Family Doctor _____ Phone_____ Family Dentist_____ Phone_____

   Health Insurance Co._____Policy I.D.#_____ Agent_____ Phone_____

In the event reasonable attempts to contact me/us at above-locations, or other person(s) named in item 4, above, full authorization is given for (1) administration of any treatment deemed to be necessary by a licensed trainer, or medical practitioner, and (2) the transfer of son/daughter or ward to any licensed trainer, or medical practitioner: and (3) the transfer of son/daughter or ward to any licensed hospital or emergency clinic reasonably accessible. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide Authority and Power on the part of school authorities and aforesaid agent(s) to give reasonable care. Facts are given below concerning the student's medical history which a medical practitioner should know.

Blood Type_____ Allergies_____ Allergies to specific medication(s)_____

Glasses or Contacts_____ False Teeth or Bridgework_____ Last Tetanus Booster_____

Any previous significant medical problems_____

Date_____ Signature of Parent or Guardian_____