SPORT ______________________

EMERGENCY MEDICAL AUTHORIZATION

PLEASE USE BALL POINT PEN

PLEASE PRINT LEGIBLY & MAKE SURE LAST COPY IS READABLE

MEDINA HIGH SCHOOL

Student Name ______________________ ID # ____________

Grade ____________ Address ______________________

Telephone ____________ City, State, Zip ______________________

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

Residential Parent or Guardian: Student's Date of Birth: ____________

Mother's Name ______________________ Work Phone ( ) ____________

Father's Name ______________________ Work Phone ( ) ____________

Guardian* (if appropriate) ______________________ Work Phone ( ) ____________

Student Living With: __ Mother & Father __ Mother __ Mother & Step __ Father __ Father & Step __ Guardian*

Name of Relative or Childcare Provider ______________________ Relationship ____________

Address ______________________ Phone ( ) ____________

List two neighbors or relatives who will assume care of your child if you cannot be reached:

Name ____________ Relationship ____________ Phone ( ) ____________
Name ____________ Relationship ____________ Phone ( ) ____________

PART I OR PART II MUST BE COMPLETED

PART I - TO GRANT CONSENT

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

Doctor ______________________ Phone ( ) ____________

Dentist ______________________ Phone ( ) ____________

Medical Specialist ______________________ Phone ( ) ____________

Preferred Hospital ______________________ Emergency Rm Phone ____________

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, 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 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: ______________________

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____________ ______________________
Date *Signature of Parent/Guardian*

Address ______________________
City, State Zip ______________________

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

PART II - REFUSAL TO CONSENT

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 school authorities to take the following action: ______________________

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____________ ______________________
Date *Signature of Parent/Guardian*

Address ______________________
City, State, Zip ______________________

Copies to: Athletic Director/Trainer/Coach