



ATHLETIC EMERGENCY MEDICAL AUTHORIZATION CARD

Return this form to the Athletic Director's office.

Do not include with mail back registration.

I.D. Number _____ Sport _____

Name _____ Class _____ Telephone (____) _____ Age _____
Last Name First Name

Parent's Name _____
Last Name First Name

Home Address _____
Street City, State Zip Code

Physician _____ Telephone (____) _____ Hospital _____

In case of emergency, attempt to contact a parent at home or at work. If we cannot be reached, attempt to contact the alternate listed below:

Alternate Name _____ Telephone(____) _____ Relationship _____

Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examination and immunizations for the above-named student. In the event of an emergency arising out of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, the treatment necessary for the best interest of the above-named student may be given.

Permission is also granted to the athletic trainer to provide the needed emergency treatment prior to the student's admission to the medical facilities.

Father's Signature _____ Date _____

Mother's Signature _____ Date _____

Work Telephone (____) _____

Work Telephone (____) _____

Allergies _____

Medications _____

Comments/Additional Instructions _____