# EMERGENCY MEDICAL AUTHORIZATION

This form must be available to the coach at all team practices and contests for each team member in order to ensure medical treatment by physicians or hospital in the event of serious injury.

PLEASE PRINT OR TYPE

Name of Athlete: ________________________________________

Date of Birth: ______________________ Age: ____________________ Sex: _________________ Grade: ___________

Allergies: ____________________________________________________________________________ (**including food**)

Current Medications: ________________________________________________________________________________

Parent (s)/Guardian(s): ______________________________________________________________________________

Address: ______________________________________________________________________________________

Home Phone: ______ - ______ - ________

Mom's cell #: ______ - ______ - ________ Dad's cell #: ______ - ______ - ________

Work Phone: ______ - ______ - ________ Work Phone: ______ - ______ - ________

Name of Insurance Company: ________________________________________________________________

Address of Insurance Company: ______________________________________________________________

Insurance Policy #: ________________________________________________________________________

Insurance Company Phone#: _________________________________________________________________

**Authorized Contact person in event parents cannot be contacted:**

Person: _______________________________________________________ Relationship: ________________________

Phone: ______ - ______ - ________

I hereby give consent for medical treatment deemed necessary by licensed physicians designated by school authorities and/or for transportation to a hospital emergency room for treatment for any illness or injury from his/her participation in athletics. I also give the care provider and/or hospital permission to release information to school officials regarding the treatment of said injury or illness.

Preferred Physician: ________________________________________________________________________________

Preferred Hospital: Home Games ________________________________________________________________

Away Games ________________________________________________________________

Remember that we play most of our games in Harrison and Hancock Counties.

_______________________________________________ ___________________

**Signature of Parent/Guardian** **Date**

List sports in which the above named student athlete may participate:

1. ______________________________________________
2. ______________________________________________
3. ______________________________________________