Emergency Medical Authorization

Grade _____ Player Name _____

Parish _____ Address _____ City _____ Zip _____

Date of Birth _____ Home Telephone _____ Cell Phone _____

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

Parent or Guardian

Mother's Name _____ Daytime Phone_____Cell_____

Father's Name _____ Daytime Phone_____Cell_____

Other's Name _____Daytime Phone_____ Cell_____

Emergency Contact (other than parent)

Name _____ Relationship _____

Address _____ Telephone_____Cell_____

PART I OR II MUST BE COMPLETED

PART I- 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 coaching authorities to take the following action:_____

_____

Signature of Custodial Parent Address of Custodial Parent Date

PART II- TO GRANT CONSENT **(DO NOT COMPLETE PART II IF YOU COMPLETED PART I)**

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

Doctor _____ Telephone _____

Dentist _____ Telephone _____

Medical Specialist _____ Telephone _____

Local Hospital _____ Emergency Room Phone _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the (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.

Circle if your child has: Heart Disease Tuberculosis Epilepsy Asthma Diabetes

Explain any allergy or disease causing difficulty:

Medications taken regularly:

_____

Signature of Custodial Parent Address of Custodial Parent Date