

# 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 \_\_\_\_\_