

ATHLETIC EMERGENCY MEDICAL AUTHORIZATION CARD

Name _____ Phone(____) _____ Birth Date _____ ID# _____ Sport _____

Home Address _____ City _____ Zip _____ Year in School FR SO JR SR

In case of emergency we will attempt to contact a parent/guardian at home or work. If one cannot be reached, we will attempt to contact the person listed as the alternate name below

Emergency Contact _____ Phone(____) _____ 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 vent of an emergency arising out of a 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 unable to communicate with me, the treatment necessary for the best interest of the above-named student may be given.

_____/_____/_____
PARENT/GUARDIAN SIGNATURE DATE

WORK PHONE CELL PHONE

HOSPITAL OF CHOICE

ASHTMA	YES	NO	_____
ALLERGIES	YES	NO	_____
HEART PROBLEMS	YES	NO	_____
DIABETES	YES	NO	_____
SEIZURES	YES	NO	_____
BLOOD DISORDERS	YES	NO	_____
DAILY MEDICATIONS IF ANY	_____		
ADDITIONAL COMMENTS/DIRECTIONS	_____		