

MEDICAL TREATMENT AUTHORIZATION

NAME _____ BIRTHDATE _____ HOME TELEPHONE _____

PARENT (GUARDIAN) _____ ADDRESS _____

FATHER'S PHONE (WORK) _____ MOTHER'S PHONE (WORK) _____

PERSON TO NOTIFY IF PARENT CANNOT BE REACHED - NAME _____

ADDRESS _____ PHONE _____ RELATION _____

PURPOSE OF THIS CARD: To enable parents or guardians to authorize the provision of emergency treatment for minors who become ill or injured while under school authority when parents or guardians cannot be reached.

In the event of an emergency requiring medical attention, I hereby grant my permission to the team physician, trainer or coach to administer first aid to my son/daughter
Yes _____ No _____

In the event of an emergency requiring further medical attention, I hereby grant my permission to _____ (family doctor) at _____ (preferred hospital) or (if not possible) to attending physician at the hospital designated by the school staff to attend my son/daughter _____. Yes _____ No _____

I expect every effort will be made to contact me in order to receive my specific authorization before any major treatment or hospitalization is undertaken.

DATE _____ SIGNATURE _____

HEALTH HISTORY

FAMILY DOCTOR _____ PHONE _____ HOSPITAL _____
INSURANCE COMPANY _____ INSURANCE CONTRACT NUMBER _____
DATE OF LAST PHYSICAL _____ DATE OF LAST TETANUS SHOT _____
MEDICAL HISTORY: YES NO
HEART CONDITION OR DISEASE _____ IF SO EXPLAIN _____
EPILEPSY _____
DIABETES _____ IF SO PLEASE STATE _____
ASTHMA _____ IF SO PLEASE STATE _____
OTHER CONDITIONS _____ IF SO PLEASE INDICATE & EXPLAIN _____
WEAR CONTACTS OR GLASSES _____ IF SO PLEASE INDICATE WHICH _____
ALLERGIC TO ANY MEDICATION _____ IF SO PLEASE LIST _____

PLEASE FILL CARD OUT COMPLETE AND SIGN IT. PLEASE NOTIFY THE SCHOOL IF ANY OF THE INFORMATION (Above or on the other side) CHANGES DURING THE SCHOOL YEAR.

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