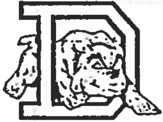
2019-2020



EMERGENCY MEDICAL AUTHORIZATION
DEFIANCE HIGH SCHOOL ATHLETICS

STUDENT NAME : ______________________

BIRTH DATE : ______________________

SCHOOL : *HIGH SCHOOL* *JUNIOR HIGH*

COMPLETE EITHER PART I or PART II (ON BACK)

PART I ...... TO GRANT CONSENT

To enable paorents and guardians to authorize emergency treatment for children who become ill or injured while under school authority and parents or guardian cannot be reached.

PARENTAL INFORMATION

PARENT /GUARDIAN NAME ______________________

HOME ADDRESS ______________________

PLACE OF EMPLOYMENT ______________________

1ST PHONE NUMBER TO CALL ______________________

ALTERNATE NUMBER TO CALL ______________________

MEDICAL INFORMATION

PREFERRED HOSPITAL / CLINIC ______________________

PREFERRED PHYSICIAN NAME ______________________
PHONE NUMBER ______________________

PREFERRED DENTIST ______________________
PHONE NUMBER ______________________

ALLERGIES / MEDICATIONS ______________________

BLOOD TYPE ______________________

INSURANCE INFORMATION

INSURANCE CO. NAME ______________________
INSURANCE CO. ADDRESS ______________________
POLICY NUMBER ______________________ GROUP NUMBER ______________________

WAIVER

In the event reasonable attempts to contact me at the phone numbers listed have been unsuccessful, I hereby give my consent for:
1. the administration of any treatment deemed necessary by my preferred physician or dentist, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist.
2. the transfer of the child to my preferred hospital/ clinic or any reasonably accessable hospital/clinic.

THIS AUTHORIZATION DOES NOT COVER ANY MAJOR SURGERY UNLESS THE MEDICAL OPINIONS OF TWO OTHER LICENSED PHYSICIANS OR DENTISTS ARE OBTAINED PRIOR TO THE PERFORMANCE OF SURGERY

****** PART II REFUSAL OF CONSENT ON BACK*

______________________ /
SIGNATURE OF PARENT OR GUARDIAN *DATE*