2020-'21

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 parents 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*