

2021-22 EMERGENCY MEDICAL



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 accessible 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

21-01

PART IIREFUSAL TO CONSENT

DO NOT COMPLETE THIS PART IF YOU COMPLETED PART I

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 to have the school authorities to take no action or to:

PARENT NAME

PARENTS ADDRESS

1ST PHONE NUMBER TO CALL

ALTERNATE NUMBER TO CALL

PARENTS/GUARDIAN SIGNATURE

/

/ DATE