

SALINA SCHOOL DISTRICT
ATHLETIC DEPARTMENT EMERGENCY MEDICAL AUTHORIZATION

This form must be made available by the coach at all team practices and contests for each participant to insure proper treatment by health care providers in the event of serious injury.

Student's Name _____
First Middle Last

Birth Date _____ Grade _____ Sex _____ Home Phone _____

Address _____ Zip _____

Mother _____ Birth Date _____

Occupation _____ Workplace _____ Business Phone _____

Father _____ Birth Date _____

Occupation _____ Workplace _____ Business Phone _____

Insurance Carrier _____ Plan _____ Policy # _____ Phone _____

In the event parents/guardians cannot be contacted, please contact:

_____ Phone _____

I hereby give my consent for any emergency care or treatment deemed necessary by the health care providers (e.g. physicians and/or athletic trainers) designated by school authorities and sponsors and/or for transportation to a hospital emergency room for treatment for any illness or injury resulting from or occurring in conjunction with his/her participation in this activity.

1. Date of last tetanus shot _____

2. Any drug allergies (Penicillin, sulfa, etc.) _____

3. Any physical condition such as diabetes, epilepsy, asthma, etc. _____

4. List any medication or medical treatment prescribed for child _____

Preferred Physician _____

Preferred Hospital _____

I understand this authorization will only be enforced when I cannot personally be contacted and provide for immediate treatment.

Sports Athlete plays _____

MUST BE SIGNED AND DATED IN FRONT OF NOTARY

Signed (Parent or Guardian) Date

Witness my hand this _____ day of _____ (month/year)

ATTEST: (seal)

State of _____

County of _____

Notary Signature