

**WARREN HILLS SCHOOL DISTRICT ATHLETIC DEPARTMENT EMERGENCY MEDICAL AUTHORIZATION**

This form must be made available by the coach at all team practices and contests for each team member to insure proper medical treatment by physicians or hospitals in the event of serious injury.

Fall sport \_\_\_\_\_

**Please print in BLACK ink (sheet will be duplicated)**

Winter Sport \_\_\_\_\_

Spring Sport \_\_\_\_\_

Athlete's Name \_\_\_\_\_ Grade (2006-07) \_\_\_\_\_ Sex (circle one) M or F

Birth Date \_\_\_\_\_ Place of Birth \_\_\_\_\_

Family physician \_\_\_\_\_ Physician's Phone # \_\_\_\_\_

Preferred hospital \_\_\_\_\_

Parent/Guardian Name(s) \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ Business Phone \_\_\_\_\_

City \_\_\_\_\_ Cell Phone \_\_\_\_\_

Emergency contact person \_\_\_\_\_ Phone # \_\_\_\_\_

Relationship to the athlete \_\_\_\_\_

I hereby give my consent for medical treatment deemed necessary by physicians designated by school authorities and/or for transportation to a hospital emergency room for treatment for any illness or injury my child may sustain during his/her athletic participation. I understand this authorization will only be enforced when I cannot personally be contacted and provide for immediate treatment.

Parent/Guardian's signature \_\_\_\_\_ Date \_\_\_\_\_

Please do not write below this line

**School Nurse's Comments:**

Medical History

\_\_\_\_ orthodontia      \_\_\_\_ wears glasses      \_\_\_\_ wears contact lenses      \_\_\_\_ negative history

Allergies:

\_\_\_\_ bee stings \_\_\_\_\_

\_\_\_\_ asthma \_\_\_\_\_

\_\_\_\_ medications \_\_\_\_\_

\_\_\_\_ other \_\_\_\_\_

Medications \_\_\_\_\_

Injuries \_\_\_\_\_

Surgeries \_\_\_\_\_

Other \_\_\_\_\_

Nurse's initials \_\_\_\_\_