

COLDWATER SPORTS EMERGENCY MEDICAL AUTHORIZATION FORM

School: _____ Student's Name: _____

Address: _____ Telephone No.: _____

Purpose – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Residential Parent or Guardian

Mother's Name: _____
First Last Daytime Phone

Father's Name: _____
First Last Daytime Phone

Name of Relative or Child Care Provider:

Name	Relationship
Address	Phone

PART I OR II MUST BE COMPLETED

PART I: TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Physician: _____ Phone: _____
Dentist: _____ Phone: _____
Medical Specialist: _____ Phone: _____
Local Hospital: _____ Emergency Room Phone: _____

FACTS CONCERNING THE CHILD'S MEDICAL HISTORY, including allergies, medications being taken, and any physical impairment to which a physician should be alerted:

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Date _____ Signature of Parent/Guardian _____

PART II: REFUSAL TO CONSENT

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 the school authorities to take the following action:

Date: _____ Signature of Parent/Guardian: _____
Address: _____