_____DETACH EMERGENCY CARD AND RETURN TO ATHLETICS_____

ATHLETIC EMERGENCY MEDICAL AUTHORIZATION CARD

Name_____Phone(___)_____Birth Date_____ID#_____Sport_____

Home Address_____City_____Zip_____ Year in School FR SO JR SR

In case of emergency we will attempt to contact a parent/guardian at home or work. If one connot be reached, we will attempt to contact the person listed as the alternate name below

Emergency Contact_____Phone(___)_____Relationship_____

Permission is herby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examination and immunizations for the above named student. In the vent of an emergency arising out of a serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is unable to communicate with me, the treatment necessary for the best interest of the above-named student may be given.

_____/_____/____

PARENT/GUARDIAN SIGNATURE DATE

_____

WORK PHONE CELL PHONE

_____

HOSPITAL OF CHOICE

ASHTMA	YES	NO	_____
ALLERGIES	YES	NO	_____
HEART PROBLEMS	YES	NO	_____
DIABETES	YES	NO	_____
SEIZURES	YES	NO	_____
BLOOD DISORDERS	YES	NO	_____

DAILY MEDICATIONS IF ANY_____

ADDITIONAL COMMENTS/DIRECTIONS_____