HS-JH ACTIVITY
EMERGENCY MEDICAL AUTHORIZATION
(MUST BE FILLED OUT AND RETURNED BEFORE FIRST DAY OF PRACTICE OR ACTIVITY)

NAME _____ DATE _____

ADDRESS _____ DOB _____

FATHER'S NAME _____ PHONE: H _____ W _____ C _____

MOTHER'S NAME _____ PHONE: H _____ W _____ C _____

ALLERGIES: _____

CURRENT MEDICATIONS: _____

MEDICACTIONS ALLERGIC TO: _____

OTHER MEDICAL INFORMATION: _____

_____

_____

FAMILY DOCTOR _____ OFFICE PHONE: _____

FAMILY DENTIST _____ OFFICE PHONE: _____

HOSPITAL PREFERENCE (IF AVAILABLE) _____

EMERGENCY ALTERNATIVE CONTACT PERSONS IN CASE PARENTS **CANNOT** BE REACHED

NAME: _____ PHONE: H _____ W _____ C _____

NAME: _____ PHONE: H _____ W _____ C _____

TO WHOM IT MAY CONCERN: I the undersigned, being the parent or legal guardian of the above named Student, do hereby grant to any hospital, emergency center, doctor, nurse, paramedic, athletic trainer and/or EMT authorization to grant treatment to my child, when accompanied by or escorted to the treating facility by a teacher, coach, coach's aide, or school administrator.

Further, should the attending physician determine after examination that life-saving surgery or other life-saving procedures may be necessary, permission is hereby extended to the above parties to grant same.

Additionally, I agree to hold harmless such personnel and the USD 482 Board of Education by my action of granting said permission. I also understand that USD 482 is not responsible for payment of any medical bills associated with treatment. I declare under penalty of perjury that the above is true and correct.

_____ _____

Parent/Guardian's Signature **Date**