Medical Authorization Form

Purpose: For parents/guardians to authorize emergency treatment for children who become ill
or injured while under school authority, when parents cannot be reached.

For: ____

Name of Athlete/Student

Address ____

City/State/Zip ____

Phone ____

Parent/Guardian ____

Contact Phone # ____

In the event reasonable to contact me ___________________________(parent/guardian) are unsuccessful, I (We), the undersigned parent/legal guardian of ____________________________,
do authorize any hospital, clinic, or licensed physician to treat my/our child and administer any x-ray examination, anesthetic, or surgical diagnosis rendered under the general or special supervision of any member of the medical staff of the hospital, clinic, or office.

Our preferred physician is _______________________________________ whose phone # is
___________________________. Our preferred dentist is
______________________________ whose phone # is
____________________________________. Our preferred hospital is
_____________________________________.

In the event the designated preferred practitioner is not available, we authorize in advance another licensed physician or dentist the authority and power to render care in his/her best judement and the transfer of the child to any hospital reasonably accessible. It is also understood that every effort shall be made to contact the parent/legal guardian prior to rendering treatment to the patient, but the treatment will not be withheld if the

parent/legal guardian cannot be contacted. Permission is also granted for the school's athletic trainer or coach to provide emergency treatment to my/our child prior to his/her admission to any medical facility.

____ Date _____________________

Signature of Parent/Guardian

List of restrictions/physical impairments:

List of special medications taken by child: