SPORT: _______________ SEASON:______________ SCHOOL YEAR:_________

Youngstown City School District Athletic Department

EMERGENCY MEDICAL AUTHORIZATION FORM

STUDENT: ____ GRADE: ________

ADDRESS: ____
CITY: ___________________________ ZIP: _______________
HOME PHONE: _______________________________________

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/Guardian Information:

Name: _______________________________ WORK PHONE: __________________________ CELL PHONE: ___________________________ EMAIL:__________________________________

LIST STUDENT MEDICAL CONTITIONS:

Father/Guardian Information:

Name: _______________________________ WORK PHONE: __________________________ CELL PHONE: ___________________________ EMAIL:__________________________________

EMERGENCY CONTACTS

1). ____ RELATIONSHIP: _______________
HOME PHONE: ______________________ CELL PHONE: ______________________

2). ____ RELATIONSHIP: _______________
HOME PHONE: ______________________ CELL PHONE: ______________________

3). ____ RELATIONSHIP: _______________
HOME PHONE: ______________________ CELL PHONE: ______________________

PART I – TO GRANT CONSENT

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

DOCTOR ______________________________ PHONE: __________________

DENTIST: ______________________________ PHONE: __________________

MEDICAL SPECIALIST: _________________________ PHONE: __________________

LOCAL HOSPITAL: ____________________________ PHONE: ___________________

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-names doctor, 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 dentist, concurring in the necessity of such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physical or coach should be alerted:

____

____

SIGNATURE OF PARENT: _______________________________________ DATE: _______

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, instead I wish the school authorities to take the following action: ____

____

SIGNATURE OF PARENT: _______________________________________ DATE: ______