

PROVIDENCE ATHLETIC DEPT. EMERGENCY MEDICAL AUTHORIZATION

***1. TYPE YOUR INFORMATION BELOW AND SUBMIT FORM BY EMAIL. 2. PRINT A COPY & SIGN. 3. TURN IN SIGNED COPY TO ATHLETIC DIRECTOR BY SEPT 1st.

STUDENT'S FIRST NAME - MIDDLE INITIAL - LAST NAME	() HOME PHONE NUMBER	GRADE
ADDRESS	CITY	ZIP

The purpose of this form is 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.

EMERGENCY CONTACTS:

	HOME PHONE	CELL PHONE
RESIDENTIAL PARENT OR GUARDIAN FIRST AND LAST NAME	WORK PHONE	
	HOME PHONE	CELL PHONE
RESIDENTIAL PARENT OR GUARDIAN FIRST AND LAST NAME	WORK PHONE	
	HOME PHONE	CELL PHONE
OTHER PARENT, GUARDIAN OR RELATIVE'S FIRST NAME AND LAST NAME (RELATIONSHIP)	WORK PHONE	
	HOME PHONE	CELL PHONE
	WORK PHONE	CELL PHONE
IF PARENT OR GUARDIAN CANNOT BE REACHED - EMERGENCY CONTACT FIRST AND LAST		

PART I OR PART II MUST BE COMPLETED

PART I: TO GRANT CONSENT I hereby give consent for the following medical care providers and local hospitals to be called in an emergency:

PHYSICIAN	() OFFICE PHONE
DENTIST	() OFFICE PHONE
MEDICAL SPECIALIST	() OFFICE PHONE
LOCAL HOSPITAL	() EMERGENCY ROOM 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-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 a 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.

Facts concerning the athlete's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted are listed as follows:

DATE _____ SIGNATURE OF PARENT/GUARDIAN _____

ADDRESS _____ CITY _____ ZIP _____

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 medical treatment, I wish the school authorities to take the following action:

DATE _____ SIGNATURE OF PARENT/GUARDIAN _____

ADDRESS _____ CITY _____ ZIP _____