Authorization for Emergency Transportation and Treatment

Student's Name_____
(Last) (First) (MI) (Grade)

Activities_____ Birth date_____

I authorize school personnel to transport my son/daughter to a physician's office and/or emergency room for treatment in the event medical care is needed while he/she is involved in either co-curricular or extra-curricular activities. Further, I authorize the Physician and Hospital Staff to treat my son/daughter as they deem necessary in the emergency situation.

Parent/Guardian Signature_____ Date_____

Insurance Company_____ Ins #_____

Medications presently taking_____

Known Allergies_____

Father's full name_____ Employment_____

Home #_____ Work #_____ Emergency #_____

Mother's full name_____ Employment_____

Home #_____ Work #_____ Emergency #_____

Family Doctor_____ Phone #_____

Family Dentist_____ Phone #_____

(Please return to the Athletic office)