Emergency Medical Authorization Sheet

NAME _____ AGE _____ Grade ___

BIRTH DATE _____ PARENTS(GUARDIANS)_____

ADDRESS _____

HOME PHONE _____ WORK PHONE _____Cell Phone _____

HEALTH CARE INFORMATION

DOCTOR _____ PHONE _____

DENTIST _____ PHONE _____

OPTOMETRIST _____ PHONE _____

INSURANCE CARRIER _____POLICY NUMBER_____

GENERAL HEALTH QUESTIONS

1. CONTACTS? YES _____ NO _____

2. ASTHMA? YES _____ NO _____
*If yes, do you want your son or daughter to leave an inhaler in the medical kit? Y or N

3. ALLERGIES? YES _____ NO _____
* If so, to what? _____

4. PROBLEMS ASSOCIATED WITH INSECT STINGS? YES ___NO_____

5. SEIZURES? YES _____ NO _____
* If yes, when was the last one? _____

6. ANY BROKEN BONES OR JOINT PROBLEMS? YES _____NO_____
* If yes, please explain.
_____

7. DO YOU HAVE HYPERVENTILATION PROBLEMS? YES _____ NO _____

8. ARE THERE ANY MEDICATIONS WE SHOULD BE AWARE OF?YES _____ NO _____
* If yes, please give name, dosage, and reason for taking medication
_____

9. ARE THERE ANY PROBLEMS THAT WE SHOULD BE AWARE OF? YES ____NO_____
* If yes, please explain. _____
_____

I GRANT PERMISSION FOR MY SON OR DAUGHTER TO BE GIVEN IMMEDIATE EMERGENCY CARE BY A PHYSICIAN IN CASE OF INJURY AS A RESULT OF ATHLETIC COMPETITION.

PARENT SIGNATURE _____ DATE _____

STUDENT SIGNATURE _____ DATE _____