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| **CROOKSVILLE HIGH SCHOOL ATHLETICS**Emergency Medical Authorization |
|  |
| Athlete Name: |  | Age: |  | Upcoming Grade: |  | Year: |  |
|  |
| **Purpose:** To enable parents to authorize emergency treatment for their children who become ill or injured while under school authority and when a parent cannot not be reached. |
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| **Emergency Contact Numbers:** |
| Parent / Guardian Name: |  | Phone #: |  | Cell/Work #: |  |
| Parent / Guardian Name: |  | Phone #: |  | Cell/Work #: |  |
| Other Emergency Contact: |  | Phone #: |  | Cell/Work #: |  |
|  |
| I hereby give my consent for (1) the administration of any treatment deemed necessary by current athletic trainer for my child. |
| (Preferred General Practitioner) **Doctor:** |  | MD |  | DO |  |
| (Preferred) **Dentist:** |  |  |
| **In the event that the preferred practitioner is unavailable, treatment can be performed by another licensed physician or dentist.** |
| (2) The transfer of the child to: (Preferred) **Hospital:** |  |
|  | **Or any hospital reasonably accessible** |
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| **Medical History:** |
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| **PLEASE SPECIFY IF CHILD IS ALLERGIC TO A MEDICATION OR IS ON ONE CURRENTLY** |
|  | Allergies: |  |
|  | Medications Taking: |  |
|  | Any Medical Conditions: |  |
|  | Any Past Orthopedic Injuries: |  |
| **Insurance:** |
| I, |  | (parent/guardian) of |  | (athlete), state |
| that I have/will have proper medical and surgical insurance to cover any and all accidents or medical injuries during |
| 2 |  | - 2 |  | (year) sport seasons: covering practices, scrimmages, games, or any other activity related with |
| the participation in athletics at Crooksville Schools. |
|  |
| **MUST HAVE!!!** |
| **Company Name:** |  |  | **Policy Number:** |  |
|  |  |  |
| Print Name: |  |
| Signature of Parent/Guardian: |  |  | Date: |  |
| Mailing Address: |  |  | Home Phone #: |  |
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