URSULINE ACADEMY ATHLETIC DEPARTMENT

EMERGENCY MEDICAL AUTHORIZATION

This form must be made available by the coach at all team practices and contests for each team member to insure proper medical treatment by physicians or hospital in the event of a serious injury.

Athlete's Name (Last, First): ______________________________

Birth Date: ____________Grade: ____________Sex: ____________

Parent's Name(s):______________________________

Home Phone: ______________ Business Phone: ______________

Parent Cell Phone: ______________ Student Cell Phone:______________

Address: ______________________________ Zip: __________

In the event the parents can not be contacted, please contact:

Name: ______________________Phone #: ____________

List sports the above-named athlete plays:

1 ______________________________

2 ______________________________

3 ______________________________

List any know allergies: ______________________________

List existing medical conditions: ______________________________

I hereby give my consent for medical treatment deemed necessary by physicians designated by school authorities and/or for transportation to a hospital emergency room for treatment for any illness or injury resulting from his/her athletic participation.

Preferred physician: ______________________________

Preferred hospital: ______________________________

I understand this authorization will only be enforced when I can not personally be contacted and provide for immediate treatment.

Parent/Guardian Signature__________________ Date: ____________