

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 _____