

PORT ANGELES SCHOOL DISTRICT

MEDICAL EMERGENCY AUTHORIZATION FORM

(TO BE COMPLETED BY PARENT AND RETURNED TO HEAD COACH)

MEDICAL INFORMATION

Name _____ Date _____
(Student)

Date of Birth _____ Height _____ Weight _____

List of Any Allergies _____

List of Required Medication _____

Other Medical History _____

Family Physician's Name _____ Phone _____

CONTACT INFORMATION

Parent's Name _____ Home Phone _____

Work Phone _____ Cell Phone _____

Address _____

Emergency Contact Person _____ Phone _____

Relationship of Contact Person _____

Name of Family Insurance Company _____ Policy # _____

MEDICAL EMERGENCY AUTHORIZATION

Name of Student Athlete _____

As Parent or Legal Guardian, I authorize the team physician or, in his absence, a qualified physician to examine the above-named student and in the event of injury to administer emergency care and to arrange for any consultation by a specialist, including a surgeon, he deems necessary to insure proper care of any injury. Every effort will be made to contact parent or guardian to explain the nature of the problem prior to any involved treatment.

Name _____ Date _____
(Signature of Parent or Guardian)