DANBURY PUBLIC SCHOOLS

INTERSCHOLASTIC ATHLETICS DEPARTMENT

EMERGENCY MEDICAL AUTHORIZATION

Name of Athlete____Sport____

Age_________________Grade________________DOB____

Parent/Guardian(s) Name____

Address____

Phone (Day)__________________________Evening_____________________Cell___________________________________

Other Authorized persons to contact in case of emergency:

Name____Phone_______________________________________

Name____Phone_______________________________________

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

CONSENT GRANT

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for 1) the administration of any treatment deemed necessary by a licensed physician, HEALTHSOUTH Athletic Trainer or dentist, and 2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history, including allergies, medications being taken, previous head/neck or back injuries, previous heat related problems, previous significant injuries, and any physical impairments to which a physician should be alerted ______________________

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Preference of Physician____(and permission to contact if needed)

Address____Phone____________________________________

Date Signed___________________________**Signature**____

(**Parent or Guardian)**

REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency medical treatment, I wish the school authorities to take no action or to:

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Date Signed____________________________**Signature**____

(**Parent or Guardian)**

MEDICAL INFORMATION

Recent medical illnesses____Medication____

(any medication needed to be taken during competition needs a physicians note)

Previous head/neck or back injuries____

Previous heat related problems____

Previous significant injuries____

Other information to inform medical staff____

Date Signed____________________________________**Signature**____

(Parent or Guardian)

STATEMENT OF INSURANCE

My son/daughter is covered for injury under a policy with ____

(Name of Insurance Company)

Policy #____Phone #____

Date Signed______________________________________Signature____

(Parent or Guardian)

***AN EXCESS INSURANCE POLICY IS PROVIDED BY THE BOARD OF EDUCATION TO SUPPLEMENT YOUR INSURANCE COVERAGE**.

Parent or Guardian

Signature:____**Date**____

PLEASE RETURN THIS FORM TO YOUR COACH