HILLIARD OPTIMIST CLUB YOUTH SPORTS

EMERGENCY MEDICAL AUTHORIZATION

PARTICIPANT NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

TELEPHONE # (IN CASE OF EMERGENCY)

NAME _____ PHONE # _____

NAME _____ PHONE # _____

(other parent or guardian)

PART I OR PART II MUST BE COMPLETED

PART I- TO GRANT CONSENT

IN THE EVENT REASONABLE ATTEMPTS TO CONTACT ME OR THE OTHER PARENT OR GUARDIAN AT THE ABOVE CONTACT NUMBERS HAVE BEEN UNSUCCESSFUL; I HEREBY GIVE MY CONSENT FOR:

1) THE ADMINISTRATION OF ANY TREATMENT DEEMED NECESSARY BY:

Preferred Physician DR._____/ (phone) _____
Preferred Dentist DR._____/ (phone) _____

OR IN THE EVENT THE DESIGNATED PREFERRED PRACTITIONER IS NOT AVAILABLE, BY ANOTHER LICENSED PHYSICIAN OR DENTIST.

2) THE TRANSFER OF THE CHILD TO _____ (preferred hospital) OR ANY HOSPITAL REASONABLY ACCESSIBLE.

THIS AUTHORIZATION DOES NOT COVER MAJOR SURGERY UNLESS THE MEDICAL OPINIONS OF TWO OTHER LICENSED PHYSICIANS OR DENTIST, CONCURRING AS TO THE NECESSITY OF SUCH SURGERY, ARE OBTAINED PRIOR TO THE PERFORMANCE OF SUCH SURGERY.

_____

SIGNATURE OF PARENT OR GUARDIAN ***DATE***

WITNESS_____ (DATE) _____

PART II-REFUSAL OF CONSENT
(DO NOT COMPLETE PART II, IF YOU COMPLETED PART I)
I DO NOT GIVE MY CONSENT FOR EMERGENCY MEDICAL TREATMENT OF MY CHILD. IN THE EVENT OF ILLNESS OR INJURY REQUIRING EMERGENCY TREATMENT I WISH THE HILLIARD OPTIMIST CLUB AUTHORITIES TO TAKE NO ACTION OR-

_____
_____

_____

SIGNATURE OF PARENT OR GUARDIAN ***DATE***

WITNESS_____ (DATE) _____