PLAYER'S NAME ____
(*Please print*) Last First

Centerville Youth Lacrosse

EMERGENCY MEDICAL AUTHORIZATION FORM

Date of Birth ______________________________ Home Phone ______________________________
School ______________________________ Address______________________________
Today's Date: ______________________Grade ________ City ______________________Zip ______________

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

Residential Parent or Guardian

Mother's Name ______________________________ Phone ______________________________
Father's Name ______________________________ Phone ______________________________
Emergency Contacts: 1. ______________________ Phone ______________________________
2. ______________________ Phone ______________________________
3. ______________________ Phone ______________________________

PLAYER HEALTH SECTION MUST BE COMPLETED

[ ] No medical conditions [ ] No allergies [ ] Medication allergy: ______________________________

Allergic to: ____

[ ] Requires treatment with epi-pen/antihistamine
[ ] No medication required for allergy treatment

[ ] **Asthma**

[ ] Requires inhaler/nebulizer
[ ] No inhaler/nebulizer required

[ ] Diabetes [ ] Requires Insulin [ ] Requires oral diabetes medications ______________________________

[ ] Seizure Disorder Type: ____

[ ] Requires Emergency rescue medication
[ ] No emergency rescue medication require

[ ] Heart/blood problems: ____

[ ] Other (Specify) ____

Medications taken at home: ____

PART I OR II MUST BE COMPLETED

PART I: TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor ______________________________Phone____________

Dentist______________________________ Phone____________

Medical Specialist______________________Phone____________

Local Hospital/Emergency Room____________Phone____________

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 above named doctors, or, in the event the designated practitioner is not available, by another licensed physician 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 other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

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Signature of Parent/Guardian Date

PART II: 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 treatment, I wish the Club authorities to take the following action:

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Signature of Parent/Guardian Date