EMERGENCY MEDICAL AUTHORIZATION
Pleasant Youth Football

Purpose: To enable parents and/or guardians to authorize the provision of emergency medical treatment for children who become ill or injured while participating when parents cannot be reached.

Participant's name: _____

Mother's name: _____

Address: _____ Phone: _____

Father's name: _____

Address: _____ Phone: _____

Part I – Emergency Medical Treatment (choose "A" or "B")

(A) Consent for Emergency Medical Treatment:

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

Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

Hospital: _____ Phone: _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by the above-named doctor, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and the transfer of my 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.

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairment to which the physician should alerted include:

_____

_____

Signature: _____ Date: _____

(B) Refusal to Consent to Emergency Medical Treatment:

I do not give my consent for emergency medical treatment for my child in the event of illness or injury requiring medical treatment and wish the following action be taken:

_____

_____

Signature: _____ Date: _____

Athletic Insurance/Liability Waiver (choose 1, 2, or 3):

I, the undersigned, being the parent, legal next of kin or legal guardian of the participant named on this form, hereby accept the responsibility for any injury he/she may receive while participating in Pleasant Youth Football and authorize any necessary medical treatment. I also accept responsibility of insurance coverage as listed below:

1. ☐ We have insurance.

Name of insurance company: _____

Policy number: _____

2. ☐ He/she has school insurance.

3. ☐ We do not have insurance; therefore, we are totally responsible for payment of any expenses.

Signature: _____ Date: _____

Existing Medical Conditions (if none, mark note "none"):

Allergies to foods, medications, etc: _____

Special medical problems/concerns: _____

Does participant carry medications at all time? ☐ Yes ☐ No

If yes, list medications: _____

If yes, do medications (e.g., inhalers) need to be kept in the team emergency kit? ☐ Yes ☐ No