CWJRD EMERGENCY MEDICAL AUTHORIZATION

Participant Name _____ Date of Birth_____

Participant Address_____ Age_____

City, State, Zip_____ Sex: Male___ Female___

School_____ Grade_____

Parent/Guardian Name _____ Phone_____
Cell_____

Parent/Guardian Name _____ Phone_____
Cell_____

PART 1 or PART 2 MUST BE COMPLETED – (If you complete part 1, do NOT complete part 2)

PART 1: TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:
Physician_____ Phone_____
Dentist _____ Phone_____
Local Hospital _____ 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 preferred practitioner is unavailable, 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 dentist, concurring in the necessity for such surgery, are obtained prior to the performance of each surgery. Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which the physician should be alerted are as follows:

Signature of Parent/Guardian _____ Date_____
Name of Parent/Guardian (Printed) _____
Address _____

PART 2: REFUSAL TO CONSENT (Do not complete if you completed Part 1)

I DO NOT give consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the following action to be taken:

Signature of Parent/Guardian _____ Date_____
Name of Parent/Guardian (Printed) _____
Address _____