



**Padua Franciscan High School
Emergency Medical Authorization
For Athletic Participation**

Student's name: _____ Date: _____

Address: _____

City: _____ Zip: _____ Home phone: _____

The purpose of this form is to enable parents or 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. This form must be completed in order to grant consent. In order for us to provide appropriate medical care, it is the sole responsibility of the parents/guardians to provide any change of contact or medical information as soon as possible to the athletic office throughout the duration of the student's participation in interscholastic athletics at Padua Franciscan High School.

Emergency contact person: _____

Emergency contact phone numbers: Home: _____

Work: _____

Cell: _____

Other emergency contact person: _____

Emergency contact phone numbers: Home: _____

Work: _____

Cell: _____

A reasonable attempt will be made to contact the person listed above.

If these attempts to contact a parent/guardian have been unsuccessful, I hereby give my consent for:

1. The administration of treatment deemed necessary by Dr. _____ his/her preferred physician or by his dentist, Dr. _____, or in the event that 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 licensed physicians or dentists, concurring on the necessity for such surgery, are obtained prior to the performance of surgery.

Please list any facts concerning the child's medical history including but not limited to allergies, medications being taken and any physical impairment to which a physician should be alerted:

Parent's name (printed)

Parent's signature

Date