SALINA SCHOOL DISTRICT
ATHLETIC DEPARTMENT EMERGENCY MEDICAL AUTHORIZATION

This form must be made available by the coach at all team practices and contests for each participant to insure proper treatment by health care providers in the event of serious injury.

Student's Name_____
First Middle Last
Birth Date_____Grade_____Sex_____Home Phone_____

Address_____Zip_____

Mother_____Birth Date_____

Occupation_____Workplace_____Business Phone_____

Father_____ _____Birth Date_____

Occupation_____Workplace_____Business Phone_____

Insurance Carrier_____Plan_____Policy #_____Phone_____

In the event parents/guardians cannot be contacted, please contact:

_____Phone_____

I hereby give my consent for any emergency care or treatment deemed necessary by the health care providers (e.g. physicians and/or athletic trainers) designated by school authorities and sponsors and/or for transportation to a hospital emergency room for treatment for any illness or injury resulting from or occurring in conjunction with his/her participation in this activity.

1. Date of last tetanus shot_____
2. Any drug allergies (Penicillin, sulfa, etc.)_____
3. Any physical condition such as diabetes, epilepsy, asthma, etc._____

   _____
4. List any medication or medical treatment prescribed for child_____

   _____

Preferred Physician_____

Preferred Hospital_____

I understand this authorization will only be enforced when I cannot personally be contacted and provide for immediate treatment.

Sports Athlete plays_____

MUST BE SIGNED AND DATED IN FRONT OF NOTARY

_____ _____
Signed (Parent or Guardian) Date

Witness my hand this _____ day of _____(month/year)

ATTEST: (seal)

State of_____

County of_____ _____
Notary Signature

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