CONRAD WEISER ATHLETIC DEPARTMENT
EMERGENCY MEDICAL AUTHORIZATION

STUDENT'S NAME_____ GRADE_____ BIRTH DATE_____ SS#_____ SPORT_____

STREET ADDRESS_____ CITY_____ STATE & ZIP_____ HOME PHONE_____

FATHER'S NAME_____ HOME PHONE_____WORK PHONE_____ CELL_____

MOTHER'S NAME_____ HOME PHONE_____WORK PHONE_____ CELL_____

STUDENT LIVES WITH_____

INSURANCE CO._____ POLICY #_____ GROUP #_____

IF UNABLE TO REACH A PARENT, PLEASE CONTACT: (LIST AN EMERGENCY CONTACT WITH PHONE NUMBER)

NAME_____ PHONE #_____ CELL #_____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING CONDITIONS? IF SO PLEASE EXPLAIN:

YES NO ASTHMA _____
YES NO DIABETES _____
YES NO FOOD OR DRUG ALLERGIES _____
YES NO BEE STING ALLERGY _____
YES NO OTHER CHRONIC OR RECURRENT CONDITIONS _____
YES NO PRESENTLY TAKING MEDICATIONS? NAME OF MEDICATION _____

IN THE EVENT OF A SERIOUS MEDICAL EMERGENCY AND I CANNOT BE CONTACTED, I GRANT PERMISSION FOR CERTIFIED ATHLETIC TRAINERS, PHYSICIANS AND HOSPITAL STAFF TO PERFORM WHATEVER MEASURES THEY DEEM NECESSARY FOR THE PRESERVATION OF HEALTH UNTIL I CAN BE CONTACTED.

PARENT AND OR LEGAL GUARDIAN'S SIGNATURE_____ DATE_____

STUDENT'S NAME_____ GRADE_____ BIRTH DATE_____ SS#_____ SPORT_____

STREET ADDRESS_____ CITY_____ STATE & ZIP_____ HOME PHONE_____

FATHER'S NAME_____ HOME PHONE_____WORK PHONE_____ CELL_____

MOTHER'S NAME_____ HOME PHONE_____WORK PHONE_____ CELL_____

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Parents: Please fill out both forms, one copy is for your child's coach and one will be on file in the Athletic Training Room. Please be advised that all HIPPA regulations will be observed.