511

POLICY

GUIDELINE

Emergency Medical Form

Coaches must carry Emergency Medical Forms for all athletes to all practices and athletic events.

Emergency Medical Authorization

Grade ________________ Player Name ________________________________

Parish ________________ Address ________________ City ________________ Zip ________

Date of Birth ________________ Home Telephone ________________ Cell Phone ________________

Purpose: To enable parents and guardians to authorize the provisions of emergency treatment for children who become ill or injured while under the coaches authority, when parent or guardians cannot be reached.

Parent or Guardian

Mother's Name ____________________ Daytime Phone ____________________ Cell ____________________

Father's Name ____________________ Daytime Phone ____________________ Cell ____________________

Other's Name ____________________ Daytime Phone ____________________ Cell ____________________

Emergency Contact (other than parent)

Name ____________________ Relationship ____________________

Address ____________________ Telephone ____________________ Cell ____________________

PART I OR II MUST BE COMPLETED

PART I- REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the coaching authorities to take the following action:____________________

____

Signature of Custodial Parent Address of Custodial Parent Date

PART II- TO GRANT CONSENT **(DO NOT COMPLETE PART II IF YOU COMPLETED PART I)**

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

Doctor ____________________ Telephone ____________________

Dentist ____________________ Telephone ____________________

Medical Specialist ____________________ Telephone ____________________

Local Hospital ____________________ Emergency Room Phone ____________________

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the (1) the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is not available, 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 dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Circle if your child has: Heart Disease Tuberculosis Epilepsy Asthma Diabetes

Explain any allergy or disease causing difficulty:

Medications taken regularly:

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Signature of Custodial Parent Address of Custodial Parent Date