Brownstown Central School Corporation
Emergency Medical Authorization

The Athletic Department is seeking your permission to have your son or daughter treated at a doctor's office or hospital in the event that he or she is found in need of emergency medical treatment. If an emergency occurs, every effort will be made to contact you. However, if such contact cannot be made, this Emergency Medical Authorization may facilitate prompt treatment.

Student Name _____ Address_____
Birth date _____ Age _____ Grade _____ Home Phone _____
Father/Guardian Name _____ Cell Phone _____
Mother/Guardian Name _____ Cell Phone _____
Father's Employer _____ Business Phone _____
Mother's Employer _____ Business Phone _____
Family Doctor _____ Phone _____
Family Dentist _____ Phone _____
Preferred Hospital _____ Insurance Company_____
ID Number _____ Group Number _____
Health Allert (allergies, medication allergies, diabetic, asthma, etc.)_____
_____
Medicine(s) Presently Taking_____

If parents cannot be contacted, list two emergency contacts.

1. Name _____ Phone _____

2. Name _____ Phone _____

Grant Consent

I give my consent for emergency medical or dental treatment for my child who may become injured or ill while under school authority. I understand this authorization does not cover any surgery unless 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.

Date: _____ Signature of Parent/Guardian _____

Refuse Consent

I do <u>not</u> give my consent for emergency medical or dental treatment for my child who may become injured or ill while under school authority. In the event of illness or injury while efforts to reach us fail, I desire the school authorities to take no action.

Date: _____ Signature of Parent/Guardian _____