STOW MUNROE FALLS HIGH SCHOOL EMERGENCY MEDICAL SPORTS CARD

(We MUST have full legal name)

NAME ______________________________ ______________________________
(Last) (First) (Middle) (Sport) (Grade)

ADDRESS ______________________________

Birth date ______________________________

Place of birth(city)________________(st)_____

CITY ______________________ Zip ______________

Home Phone # ______________________

FATHER'S NAME ______________________________

same address ___yes ___no

FATHER'S PLACE OF EMPLOYMENT ______________________

Home Phone # ______________________

Work Phone # ______________________

Cell/Pager-Father ______________________

MOTHER'S NAME ______________________________

same address ___yes ___no

MOTHER'S PLACE OF EMPLOYMENT ______________________

Home Phone # ______________________

Work Phone #______________________

Cell/Pager-Mother ______________________

GUARDIAN
(if different than parent) ______________________________

Home ________________Work __________

1 ALTERNATE CONTACT ______________________________
(Name) (Relationship) (Phone)

2 ALTERNATE CONTACT ______________________________
(Name) (Relationship) (Phone)

Parents Email Address ______________________________

MEDICAL ALERT: ______________________________

MEDICATIONS: ______________________________

(PLEASE COMPLETE BACK)

EMERGENCY MEDICAL AUTHORIZATION

PURPOSE – To enable parents and 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. PART I or PART II must be completed.

PART I – TO GRANT CONSENT

In the event reasonable attempts to contact me at ______________________ (phone number) , or ______________________ , other parent or guardian at ______________________ (phone number) have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by Dr.______________________, physician, or ______________________, dentist, 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 ______________________(hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentist, concurring in the necessity for such surgery are obtained prior to the performance of such surgery. Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted.

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Date ________________ ______________________
Signature of Parent or Guardian

Address ______________________________

Part II – 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 school authorities to take not action or to

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Date ________________ ______________________

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Signature of Parent or Guardian

Address ______________________________