GRANVILLE RECREATION DISTRICT

EMERGENCY MEDICAL AUTHORIZATION

This form will be made available to the coach at all team practices and contests for each team member to insure proper medical treatment by physicians or hospital in the event of a serious injury.

Athlete's Name ____

Birth Date ______________________ Age ________ Grade ________ Sex ______________

Parent's Name ____

Home Phone ___________________________ Cell/Work Phone_________________________

Address ____

City ____ Zip Code _____________________

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

____at phone # __________________

Relationship to athlete: ____

Past injuries or illnesses that may affect participation: __________________________________

____

Medical alerts or major health concerns (i.e. Food allergies, asthma): ______________________

____

I hereby give my consent for medical treatment deemed necessary by medical personnel and/or for transportation to a hospital emergency room for treatment for any illness or injury resulting from his/her participation.

Preferred physician ____

Preferred hospital ____

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

____ ____________________

Signed (Parent or Guardian) Date