CHARIHO REGIONAL SCHOOL DISTRICT
ATHLETIC DEPARTMENT

EMERGENCY MEDICAL AUTHORIZATION FORM

This form is made available by the coach for each team member to help insure that proper medical treatment by a physician(s) or a hospital is obtained in the event of an injury. Every effort by the coach or their representative will be made to contact the proper authorized individual(s) concerning the medical condition of the athlete.

ATHLETE'S NAME____ D.O.B.___________________

PARENT'S NAME____HOME TEL.________________

CELL _____________________

ADDRESS____

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* In the event the parent(s) cannot be contacted, please contact the following individual:

NAME____ TEL._____________________

Please indicate any factors concerning the athlete's medical history including allergies, medications being used and any physical conditions for which a physician or hospital should be aware of.

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I HEREBY GIVE MY CONSENT FOR MEDICAL TREATMENT DEEMED NECESSARY BY AN EMERGENCY MEDICAL PERSONNEL AND/OR TRANSPORTATION TO AN EMERGENCY FACILITY FOR THE TREATMENT OF ANY INJURY OR ILLNESS FROM HIS/HER ATHLETIC PARTICIPATION.

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Signed Date