ST. MARTIN ATTENDANCE CENTER ATHLETICS
EMERGENCY MEDICAL AUTHORIZATION

This form must be available to the coach at all team practices and contests for each team member in order to ensure medical treatment by physicians or hospital in the event of serious injury.
PLEASE PRINT OR TYPE

Name of Athlete: _____

Date of Birth: _____ Grade: _____ Sex: _____

Birth Certificate (or) Social Security Number: _____

Parent/Guardian: _____

Address: _____

Home phone: _____ Business Phone: _____

Authorized contact person in event parents cannot be contacted:

_____ Phone: _____

List sports in which the above named student athlete may NOT participate:

1. 3.

2. 4.

I hereby give my consent for medical treatment deemed necessary by licensed physicians designated by school authorities and/or for transportation to a hospital emergency room for treatment for any illness or injury resulting from his/her participation in athletics.

Preferred physician: _____

Preferred hospital: _____

ALLERGIC TO: _____

I understand this authorization will only be enforced if I/we cannot be contacted and provide immediate treatment.

_____ _____

Signature of parent/guardian Date