**DOVER SCHOOL DISTRICT**

Dover High School-101 Pirates Loop/Dover Middle School-135 College Street

Dover, AR 72837

Phone-479-331-2120 Fax-479-331-3286/Phone-479-331-4814 Fax-479-331-4965

**Medical Consent Authorization for Travel**

This form will enable your student-athlete’s Coach, Teacher, or Director to seek Emergency Personnel to treat and if needed to admit to an Emergency Facility for treatment in your absence. We hope to never need this, but in case of an emergency, we want the best possible treatment for your student-athlete with no delays. If you have any questions, please contact your student-athlete’s Coach.

**Student’s Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DOB:**\_\_\_\_\_\_\_\_\_\_\_\_\_**Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information:**

Insurance Provider Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Provider Information:**

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physician’s Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic Name & Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ After Hours Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In Case of an Emergency Contact:**

Parent Name Daytime Phone # Evening Phone# Cell #

2nd Emergency Contact: Name Phone # Relationship

**List Any Known Drug Allergies:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Known Medical Alerts and Medications**

*This information is included to provide information to emergency personnel for medical emergency and/or for medication administration after school hours by school staff*. *(Please continue on back if needed)*

**Existing Medical Alerts Medication Taken Dosage Taken Dosage Frequency**

**(Example: Asthma) (Example: Combivent) (Example: 2 puffs) (Example: Twice Daily)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Consent Authorization:**

In the event of an injury, accident, illness or other emergency, and if the above stated physician cannot be reached, I authorize my child to be treated by certified emergency personnel such as emergency medical technicians, emergency room physicians, and other emergency room personnel such as nurses and laboratory technicians. I agree to accept all financial responsibility for the costs related to this medical treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Student’s Name Phone # Date Signed**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Authorized Parent or Guardian Phone # Date Signed**