Emergency Medical Authorization Form

Name of Event Child Participant: _____DOB: _____ Phone: _____

Address: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to medications: _____

Current medications: _____

In the event of an emergency, contact:
Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO _____ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.), OSTEOPATH (D.O.) OR DENTIST (D.D.S.) AND ARRANGE TRANSPORTATION FOR THE SAME, IF NEEDED, FOR THE EVENT CHILD PARTICIPANT NAMED ABOVE. THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE EVENT CHILD PARTICIPANT NAMED ABOVE.

_____ _____
Parent or Guardian (Print Name) (Date)

_____ _____
(Signature) (Address)

_____
(City, State, Zip)

_____
(Phone Number & Email Address)