



5412 67th Avenue West • University Place, Washington 98467 • (253) 564-6276 • www.heritagecs.net
Doing all for the glory of God – 1 Corinthians 10:31

MEDICAL EMERGENCY AUTHORIZATION FORM

TO BE COMPLETED BY PARENT AND RETURNED TO SCHOOL PRINCIPAL'S OFFICE

Name of Student Athlete _____

As Parent or Legal Guardian, I authorize the team physician or, in his absence, a qualified physician to examine the above-named student and in the event of injury to administer emergency care and to arrange for any consultation by a specialist, including a surgeon, he deems necessary to insure proper care of any injury. Every effort will be made to contact parent or guardian to explain the nature of the problem prior to any involved treatment.

Name _____ Date _____
(Signature of Parent or Guardian)

Parent's Home Phone _____ Business Phone _____

Emergency Contact Person

Name _____ Phone _____

Relationship of contact person _____

Family Physician's Name _____ Phone _____

Name of Family Insurance Company _____ Policy # _____

=====
===

FOR SCHOOL USE ONLY:

Completed Form Received _____
_____ Date _____ Name _____

Duplicate Copy Distributed to _____

on _____
Date

Insurance coverage by parents Yes _____ No _____ Unknown _____

One copy filed in Student Permanent Record: _____ Date _____ By _____ Name _____