EMERGENCY MEDICAL AUTHORIZATION / ANNUAL INTERVAL HISTORY FORM

Student Name_____ Age_____ Birthdate_____ Grade_____

Address_____ Parents Names_____

Home Phone #_____ Parent Cell #_____ Parent Cell #_____

Parent Email_____ (for use by Coach/Ath. Dept./Booster Club)

Please circle the appropriate answer and explain any yes answers concerning the above named athlete:

- Is allergic to medication no yes_____
- Takes medication now no yes_____
- Has had recent injuries requiring medical attention no yes_____
- Has had recent illness lasting more than a week no yes_____
- Is under a physician's care now no yes_____
- Any physical impairments no yes_____
- Has allergic reaction to insect stings no yes_____

Please check appropriate areas: Wears glasses □ yes Contacts □ yes

Has been prescribed medication for emergency use: □ inhaler □ epinephrine □ glucagon injection

Additional information for emergency use medication_____

PARENT/GUARDIAN PERMISSION TO PARTICIPATE & INSURANCE ARRANGEMENT

My above named son or daughter is physically able to participate in sports. Because I want my above named son or daughter to have the privilege of participation in competitive school athletics, I therefore give my permission for him/her to compete in all sports approved by Philomath School District 17J Board of Education and travel with a coach or designee on any regularly scheduled trips.

While I expect the school authorities to exercise reasonable precautions to avoid injury, I understand that they assume no financial obligation for any injury that may occur. I am advised that students are held responsible for all players' equipment owned and issued by the school. As a parent/guardian I understand the potential risk of injury/ paralysis/death associated with my child's participation in athletics. I further understand that my son/daughter must be covered by insurance prior to any participation.

_____

PARENT/GUARDIAN SIGNATURE (REQUIRED)

Insurance is available through a program made available by the school district. If a student athlete wishes to purchase this insurance as their sole coverage, he/she must show proof of enrollment prior to any participation.

_____ _____

NAME OF INSURANCE GROUP AND/OR ID NUMBER

NOTE: Part I *OR* Part II BELOW MUST BE COMPLETED

PART I: CONSENT FOR EMERGENCY MEDICAL TREATMENT

In the event reasonable attempts to contact me at the above phone numbers have been unsuccessful, I hereby give my consent for:

1. the administration of any treatment deemed necessary by Dr._____(physician) or Dr._____(dentist), or, in the event the designated preferred practitioner is not available to another licensed physician or dentist; and/or

2. the transfer of the child to _____(preferred hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery

Parent/Guardian Signature_____ Date_____

PART II: REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment for my child. In the event of illness or injury requiring emergency treatment, the school authorities should:

_____

Parent/Guardian Signature_____ Date_____

This form must be turned in with the athlete's clearance card papers. *Sport*_____