MEDICAL AUTHORIZATION CARD

Student	D.O.B.	Identify Allergies or Special Conditions

I/We, being the parent(s) or legal guardian(s) of the above-named minor, do hereby appoint:

Coach	Address	Telephone

to act on my/our behalf in authorizing unexpected medical, dental, surgical care and hospitalization for the above-named minor during the period of my/our absence, from:

Month	Day	Year		Month	Day	Year
			through			

This document shall be presented to a physician, dentist, or appropriate hospital representative at such time as unexpected medical, dental, surgical care, or hospitalization may be required.

PARENT/GUARDIAN

Signature	Date	Home Phone	Cell Phone

Address	Work Phone

OTHER EMERGENCY CONTACT PERSON

Signature	Date	Home Phone	Cell Phone

Address	Work Phone

HOSPITALIZATION COVERAGE FOR ABOVE-NAMED MINOR

Insurance Company or Government Program	I.D. or Contract Number

FAMILY PHYSICIANS

Name and Phone Number	Name and Phone Number