

MEDICAL AUTHORIZATION CARD

Sport _____

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 _____

--	--