

Medical Authorization Form for Sullivan County High School Athletics
EMERGENCY INFORMATION

Name _____

Sex: M ___ F ___ Social Security # _____ Grade: _____ Age: _____ Date of Birth: _____

Parent's name _____

Home address _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Work Address _____

Additional Person to Contact _____ Relationship to Student _____

Home Phone # _____ Cell phone # _____ Work Phone # _____

Insurance Carrier _____ Policy and group # _____

Student's Physician phone # _____

Allergies _____

Known Health Problems _____

Permission for Participation in Sullivan County School Athletics

I give consent for my child to participate/represent Sullivan County Schools in any sport. (Specify exclusions _____)

X _____ (parent/guardian signature) _____ (date)

Permission for Emergency Medical Treatment

In the event of an emergency, I give my permission for emergency treatment and/or transportation by emergency personnel to the nearest healthcare facility at a cost assumed by the parent/guardian. I also give permission for emergency treatment in a hospital, including surgery requiring the use of anesthetic (This form will be sent with emergency personnel to facility)

X _____ (parent/guardian signature) _____ (date)

Permission for Attending Physician

There may be a physician attending a specific practice or athletic event. I give my permission for any physician who is present to provide emergency medical treatment to my child if needed.

X _____ (parent/guardian signature) _____ (date)

Permission for Athletic Trainer

There may be an athletic trainer present who is under the direction and guidance of a Physician. I authorize the Athletic Trainer who is present to render first aid, or emergency care to protect the health and well being of the above individual.

X _____ (parent/guardian signature) _____ (date)

Permission for prescription and other over-the-counter medications as attached

Prescription medications must have the original pharmacy label on the container and must state the athlete's name, dosing instructions, ingredients and measurement.

If over-the-counter medication supplied from home/parent, it must be in its original labeled, unopened container with original label listing ingredients, dosing instructions, and measurement with athlete's name written in ink, on the container.

Student has my permission to receive over-the-counter medication from Athletic Trainer as listed on attachment for emergency first aid purposes.

I give my permission for authorized/trained school personnel or athletic trainer to assist my child with the self-administration of prescription medication and over-the-counter medication, and appropriate first aid which follow the above guidelines.

X _____ (parent/guardian signature) _____ (date)

*****Please include a copy of your child's insurance card with this form*****

**Note: Additional forms will need to be completed for any chronic illness/condition such as asthma, allergies, diabetes, seizure disorder, etc. Please call your school's nurse for the appropriate forms.