

Emergency Medical Authorization Form
Confidential Medical Information/Protected Health
Information Calvert High School

THIS DOCUMENT MUST BE SIGNED AND RETURNED TO ATHLETIC
DEPARTMENT BEFORE YOU WILL BE PERMITTED TO TAKE PART IN ANY
PRACTICES OR CONTESTS.

Student's Name: _____ Birthdate: _____ Grade: _____
(Last Name) (First Name) (Middle Initial)

Address: _____ City: _____ Zip: _____

Phone Number: () _____ Cell: () _____

Purpose: To enable parents/guardians to authorize the provision of treatment for students who become ill or injured while under school authority, when parents or guardians cannot be reached.

Legal Guardian(s) Name: _____ Day/work Phone: () _____

Currently living with: Parents Mother Father
 Other - explain: _____

Mother's Name: _____ Day/Work Phone: () _____

Place of Employment: _____ Occupation: _____

Father's Name: _____ Day/Work Phone: () _____

Place of Employment: _____ Occupation: _____

PART I or PART II MUST BE COMPLETED

Part I - To Grant Consent

I hereby give my consent for the following medical care providers and local hospital to be called:

Physician: _____ Office Phone: () _____

Dentist: _____ Office Phone: () _____

Medical Specialist: _____ Office Phone: () _____

Hospital: _____ Hospital Phone: () _____

Is the student on any medication: Yes No

Please list: _____

Does the student have any allergies: Yes No

Please list: _____

Does the student have any impairment: _____ Yes _____ No

Please list: _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the above-named doctors, or in the event designated preferred practitioner is not available, by another licensed physician or dentist, and transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in necessity for such surgery, are obtained prior to the performance of such surgery.

Signature of Parent/Guardian: _____ Date: _____

Part II - Refusal to Consent

I do NOT give my consent for emergency medical treatment of my child. In the event of an illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

Signature of Parent/Guardian: _____ Date: _____

Part III - Permission for Participation & Accident Waiver

The above named student has my permission to participate in interscholastic athletics at Calvert Catholic Schools during the 2011-2012 school year, and as his/her parent and/or legal guardian I understand that it will be my responsibility to accept the responsibility for medical bills resulting from injury.

Signature of Parent/Guardian: _____ Date: _____

Part IV - School Athletic Training Rules & Academic Eligibility Requirement

Each Student-athlete is provided with a student handbook and a copy of each sport's training rules and OHSAA eligibility requirements. The Athletic Department wishes that each student-athlete and his/her parents or guardian to become familiar with the rules and regulations established. Signing below indicates that each has read the rules and agrees to abide by them.

Signature of Parent/Guardian: _____ Date: _____

Signature of Student Athlete: _____ Date: _____

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