

**DANBURY PUBLIC SCHOOLS**  
**INTERSCHOLASTIC ATHLETICS DEPARTMENT**  
**EMERGENCY MEDICAL AUTHORIZATION**

Name of Athlete \_\_\_\_\_ Sport \_\_\_\_\_

Age \_\_\_\_\_ Grade \_\_\_\_\_ DOB \_\_\_\_\_

Parent/Guardian(s) Name \_\_\_\_\_

Address \_\_\_\_\_

Phone (Day) \_\_\_\_\_ Evening \_\_\_\_\_ Cell \_\_\_\_\_

*Other Authorized persons to contact in case of emergency:*

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

**PURPOSE:** To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

**CONSENT GRANT**

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 a licensed physician, Select Medical Athletic Trainer or dentist, and 2) the transfer of the child to any hospital reasonably accessible.

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

Facts concerning the child's medical history, including allergies, medications being taken, previous head/neck or back injuries, previous heat related problems, previous significant injuries, and any physical impairments to which a physician should be alerted \_\_\_\_\_

Preference of Physician \_\_\_\_\_ (and permission to contact if needed)

Address \_\_\_\_\_ Phone \_\_\_\_\_

Date Signed \_\_\_\_\_ Signature \_\_\_\_\_

(Parent or Guardian)

**REFUSAL TO CONSENT**

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency medical treatment, I wish the school authorities to take no action or to:

\_\_\_\_\_

\_\_\_\_\_

Date Signed \_\_\_\_\_ Signature \_\_\_\_\_

(Parent or Guardian)

**MEDICAL INFORMATION**

Recent medical illnesses \_\_\_\_\_ Medication \_\_\_\_\_

(any medication needed to be taken during competition needs a physicians note)

Previous head/neck or back injuries \_\_\_\_\_

Previous heat related problems \_\_\_\_\_

Previous significant injuries \_\_\_\_\_

Other information to inform medical staff \_\_\_\_\_

Date Signed \_\_\_\_\_ Signature \_\_\_\_\_

(Parent or Guardian)

**STATEMENT OF INSURANCE**

My son/daughter is covered for injury under a policy with \_\_\_\_\_

(Name of Insurance Company)

Policy # \_\_\_\_\_ Phone # \_\_\_\_\_

Date Signed \_\_\_\_\_ Signature \_\_\_\_\_

(Parent or Guardian)

**\*AN EXCESS INSURANCE POLICY IS PROVIDED BY THE BOARD OF EDUCATION TO SUPPLEMENT YOUR INSURANCE COVERAGE.**

**Parent or Guardian**

Signature: \_\_\_\_\_ Date \_\_\_\_\_

PLEASE RETURN THIS FORM TO YOUR COACH