



Emergency Medical Authorization

Player's Name _____ Birth Date _____ Age of Player _____
Address _____ City _____ ZIP _____
Telephone (Home) _____

Purpose

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

**Part A or Part B Must Be Completed But Not Both*

PART A

In the event reasonable attempts to contact me at (phone) _____ or (other parent or guardian) _____ at (phone) _____ have been unsuccessful, I hereby give my consent for:

- 1) the administration of any treatment deemed necessary by (preferred physician) Dr. _____ or (preferred dentist) Dr. _____, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist: *and*
- 2) the transfer of the child to (preferred hospital) _____, or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other 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 and any physical impairments to which physician should be alerted: _____

Signature of Parent of Guardian _____
Address _____ Date _____

PART B — REFUSAL OF CONSENT

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

Signature of Parent of Guardian _____
Address _____ Date _____