

FLAG CITY YOUTH FOOTBALL

EMERGENCY MEDICAL AUTHORIZATION

Players Name: _____ Team: _____

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for players who become ill or are injured while participating in programs sponsored by FLAG CITY YOUTH FOOTBALL and while under the authority of its coaches and other representatives when the said parents and guardians cannot be reached.

COMPLETE EITHER PART ONE OR PART TWO OF THIS FORM IN INK AND BOTH PLAYER AND PARENT SIGN PART THREE

PART ONE:

In the event that representatives of the FLAG CITY YOUTH FOOTBALL program have been unsuccessful in making reasonable attempts to contact me or the other person designated by me with the information provided below, I hereby give them my consent to authorize the following: (1) the administration of any treatment deemed necessary by the preferred physician or preferred dentist listed below, 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 the preferred hospital listed below or any hospital reasonably accessible.

This authorization **does not** cover major medical surgery unless the medical opinions of two other licensed physicians or dentists concur in the necessity for such surgery and are obtained BEFORE the surgery is PREFORMED.

Facts concerning the child's medical history, including allergies, physical impairments, last tetanus shot and medications being taken, to which a physician should be alerted are as follows: _____

Allergies: _____

Medications Taken (including dosage and times taken): _____

Medical History (including health problems such as asthma, vision, epilepsy, diabetes, hearing, bone or muscle problems, etc.): _____

Preferred Physician: Dr. _____ Phone: _____

Preferred Dentist: Dr. _____ Phone: _____

Name of Health Insurance Plan: _____
Group # _____ Member # _____

Other Responsible Person: _____ Phone: _____

Signature of Parent/Guardian: _____ Date: _____

Address: _____ Home Phone: _____

Work Phone: _____ Cellular Phone: _____

PART TWO: (DO NOT FILL OUT IF YOU HAVE FILLED OUT PART ONE)

I **DO NOT** give my consent for the emergency medical treatment of my child. In the event of illness or injury requiring emergency medical treatment, I wish the coaches and/or other representatives of Flag City Youth Football to take no action or do as follows: _____

Signature of Parent/Guardian: _____ Date: _____

Address: _____ Home Phone: _____

PART THREE: (BOTH PLAYER AND PARENT/GUARDIAN SHOULD SIGN REGARDLESS OF WHICH PART ABOVE HAS BEEN COMPLETED)

Signature of Player: _____

Signature of Parent/Guardian: _____