Tiverton High School
Athletic Department

Emergency Medical Authorization

This form must be made available by the coach at all team practices and contest for each team member to insure proper medical treatment by physicians or hospital in the event of serious injury.

Athlete's Name_____

Birth Date_____Grade_____Sex_____

Parent's Name_____

Home Phone_____Business Phone_____

Address_____Zip Code_____

In the event the parents cannot be contacted, please contact:

_____at phone #_____

List sports the above-named athlete plays:

1._____

2._____

3._____

I hereby give my consent for medical treatment deemed necessay by physicians designated by school authorities and/or for transportation to a hospital emergency room for treatment for any illness or injury resulting from his/her athletic participation.

Preferred physician_____

Preferred hospital _____

I understand this authorization will only be enforced when I cannot personally be contacted and provide for immediate treatment.

_____ _____

Signed (Parent or Guardian) Date