

**2018-19 HOCKINSON HIGH SCHOOL
MEDICAL EMERGENCY AUTHORIZATION FORM**

(Please Print Neatly and in Ink)

Name of Student: _____ Birth Date: ____/____/____ Grade: ____

As the parent/legal guardian of the above-named student, I authorize emergency care to be given to the above student in the event of an injury or emergency situation. I authorize a qualified physician to examine the above student, to administer emergency care and to arrange for consultation by a specialist, including a surgeon, as he/she deems necessary to insure proper care of injury. I authorize emergency transportation if deemed necessary. I understand every effort will be made to contact the parent/guardian to explain the nature of the situation prior to any involved treatment.

Date: _____

Parent/Guardian Name (please print): _____

Parent/Guardian Signature _____

Parent/Guardian's best contact number/s: _____

Parent/Guardian's best email: _____

Emergency Contact Person (if above cannot be reached) _____

Relationship: _____ Phone: _____

Family Physician's Name: _____ Phone: _____

Family Medial Insurance Co _____ Policy #: _____

Any Know Medical Conditions: _____

Allergies: _____

Date of Last Tetanus: _____

SPORT: Fall _____ Winter _____ Spring _____

ACTIVITIES: _____
