# Enterprise School District
# Athletic Department

## Emergency Medical Authorization

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

Athlete's Name_____

Birth Date_____ Grade_____ Sex_____

Parent/Guardian Name(s)_____

Home #_____Cell#_____Work #_____

Address_____

If the parent(s) cannot be contacted, please contact:_____

_____at Phone #_____

List sports the above named athlete is involved in:

_____ _____ _____

Medical Insurance Company_____

Policy Number_____

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

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

_____ _____

**Signed (Parent/Guardian)** Date