

NAME: Last _____ First _____ Phone _____ Birth date _____

Home Address _____ City _____ Zip _____

Physician _____ Phone _____ Hospital _____

In case of emergency, attempt to contact a parent at home or at work. If we cannot be reached, attempt to contact the alternate listed below:

Alternate name _____ Phone _____ Relationship _____

Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examinations and immunizations for the above-named student. In the event of an emergency arising out of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, the treatment necessary for the best interest of the above-named student may be given.

Permission is also granted to the Athletic Trainer to provide the needed emergency treatment to the athlete prior to his/her admission to the medical facilities.

Father's Signature _____ Date _____
Work Phone _____

Mother's Signature _____ Date _____
Work Phone _____

Comments or added directions _____

ATHLETIC EMERGENCY MEDICAL AUTHORIZATION CARD – WHEATON WARRENVILLE SOUTH H.S.