

Springboro Youth Wrestling EMERGENCY MEDICAL AUTHORIZATION

The purpose of this form is to enable parents/guardians to authorized the provisions of emergency treatment for children who become ill or injured while involved in Springboro Youth Wrestling when parents cannot be reached and to authorize the release of medical information to the coaching staff who have responsibility for the child while the child is at a wrestling event.

Wrestler's Information

Child's Name: _____ Grade _____

Address: _____ Home Phone: _____ Cell Phone: _____

Mother's Name: _____ Daytime Phone: _____ Cell Phone: _____

E-Mail: _____ @ _____

Father's Name: _____ Daytime Phone: _____ Cell Phone: _____

E-Mail: _____ @ _____

Other Name: _____ Daytime Phone: _____ Cell Phone: _____

Emergency Contacts (will be called in the order given if parent/guardian CAN Not be reached)

1. Name _____ Relationship _____ Phone _____ Cell _____

2. Name _____ Relationship _____ Phone _____ Cell _____

3. Name _____ Relationship _____ Phone _____ Cell _____

4. Name _____ Relationship _____ Phone _____ Cell _____

Emergency Care Information

Preferred Physician _____ Phone _____ Fax _____

Preferred Dentist _____ Phone _____ Fax _____

Preferred Hospital _____ Phone _____ Fax _____

Allergies and/or Specific Health Considerations: _____

CONSENT

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by the above mentioned doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists concurring in the necessity for such surgery are obtained prior to performance of such surgery. In addition to the aforementioned information, I give my permission for any and all medical information to be shared with all wrestling personnel that interact with my child.

Parent / Guardian Signature: _____ Date _____

REFUSAL TO CONSENT

I Do Not give by consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the wrestling program authorities to take no action or to: (please explain)

Parent / Guardian Signature _____ Date _____
