NORTHMONT SOCCER ASSOCIATION

EMERGENCY MEDICAL AUTHORIZATION

Division/Team No. _____

Player Name _____

Address _____

Telephone _____

Purpose — To enable parents to authorize emergency treatment for children who become ill or injured at S.A.Y. practices or games, when parents cannot be reached.

PART I OR II MUST BE COMPLETED

PART I (TO GRANT CONSENT)

In the event reasonable attempts to contact me at _____ (phone number) or _____ (other parent) at _____ (phone number) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. _____ (preferred physician) or Dr. _____ (preferred dentist), or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist: (2) the transfer of the child to _____ (preferred hospital) or 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 before the surgery is performed.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted: _____

Date _____

Signature of Parent _____

Address _____

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

PART II REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the S.A.Y. authorities to take no action or to:

Date _____

Signature of Parent _____

Address _____