NORTH WARREN CENTRAL SCHOOL
EMERGENCY MEDICAL AUTHORIZATION

Athlete_____DOB_____
Parent _____
Address_____
Phone: Home_____Work_____Cell_____

Person to contact if parent cannot be reached:
Name_____
Phone:Home_____Work_____Cell_____

Name_____
Phone:Home_____Work_____Cell_____

Family Physician_____Phone:_____
Family Dentist_____Phone:_____

CONSENT OF PARENT OR GUARDIAN FOR EMERGENCY TREATMENT:
In the event that reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by a licensed physician or dentist.

This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Please list ***all*** information concerning the child's medical history including asthma, allergies, any medications, medical conditions and physical impairments to which a physician should be alerted: _____
_____
_____
_____
_____
_____

Parent's Signature_____Date_____

Note: The school district is not responsible for contact lenses/glasses that are misplaced or damaged.