WESTFIELD SCHOOL DISTRICT
ATHLETIC DEPARTMENT
EMERGENCY MEDICAL AUTHORIZATION

This form must be available by the coach at all team practices and contests for each team member to insure proper medical treatment by physicians or hospital in the event of serious injury. **Please use black ink and write clearly, so it can be easily read.**

ATHLETE'S NAME _____

BIRTH DATE _____ **GRADE** _____ **SEX** _____

PARENT'S NAME _____

HOME PHONE _____ **BUSINESS PHONE** _____

ADDRESS _____ **ZIP** _____

IN THE EVENT THE PARENTS CANNOT BE CONTACTED, PLEASE CONTACT:

_____ ***PHONE #*** _____

PLEASE LIST ANY KNOWN ALLERGIES _____

List sports the above-named athlete participates in:

1._____2._____3._____

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

PREFERRED PHYSICIAN _____

PREFERRED HOSPITAL _____

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

_____ _____

Signed (Parent or Guardian) Date