Westport Jr./Sr. High School Athletic Department

Medical Authorization & Emergency Treatment Form

I give permission for the evaluation/treatment of _____, by a duly
Student's name-(please print)

licensed physician and/or hospital facility in the event of illness or injury. I also authorize transportation in an

ambulance if necessary. **Parent/Guardian Signature: _____ Date: _____**

CONTACT INFORMATION

Address_____ City_____ Zip Code_____

Date of Birth_____ Telephone #_____ Age _____

Sport(s) _____ Grade_____

Parent/Guardian's Name _____Work #_____ Cell #_____

Emergency Contact 1: _____
(name) (phone) (email) (relationship)

Emergency Contact 2:_____
(name) (phone) (email) (relationship)

Athlete's Primary Care Physician's Name & Telephone #: _____

MEDICAL HISTORY

My Son/daughter has previously sustained head injury or concussion: Yes_____ No_____

If yes, provide information to head injury or concussion history, including frequency: _____

_____

Diabetes:_____ Epilepsy:_____ Heart condition:_____ Asthma:_____ Other:_____

For Asthma, does athlete use inhaler? Yes_____ No____ Does Athlete wear contact lenses to play? Yes_____ No____

Please list **ALL** medications, including inhalers and directions for use:_____

_____

Please list **ALL** allergies, including medications, food, and insects: _____

_____

Please list any other pertinent medical information:_____

INSURANCE INFORMATION

Policy Name:_____ Policy #:_____ Subscriber's Name: _____

I give permission for the Westport Jr./Sr. High School medical staff to share any pertinent medical information, concerning my son or daughter, to EMT's, team, or other physicians in relation to any incurred injury or illness sustained by student-athlete, during participation.

Parent/Guardian Signature: _____ **Date:** _____

Student-Athlete Signature: _____ **Date:** _____