



Fellowship Christian School

One Family: Learning, Serving, Sharing & Transforming the World

MEDICAL EMERGENCY AUTHORIZATION FORM

TO BE COMPLETED BY PARENT/GUARDIAN AND RETURNED TO SCHOOL

Name of Student Athlete: _____

Student Athlete Age/DOB _____ Grade: _____

Name of Parent/Guardian: _____

As Parent or Legal Guardian, I authorize the coach(es) or a physician to examine the above-named student and in the event of injury to administer emergency care and to arrange for any consultation by a specialist, including a surgeon deemed necessary to insure proper care of any injury.

Every effort will be made to contact the parent or guardian to explain the nature of the problem prior to any involved treatment.

Name _____ Date _____
(Signature of Parent or Guardian)

Parent's Home Phone: _____ Business Phone _____

Emergency Contact Person: _____ Relationship: _____

Emergency Contact Person's Number: _____

Family Physician's Name _____ Phone: _____

Name of Family Insurance Company _____ Policy # _____

Medical History: Please list any medical history that could be pertinent to the care of your child.

Medications Being Taken: Please list the exact type and amount of any medications being taken.

Allergens: Please list anything your child is allergic to.