

# EMERGENCY MEDICAL AUTHORIZATION



**Eveleth-Gilbert  
ATHLETIC  
Department**

**SPORT:** \_\_\_\_\_

This form must be available by the coach at all practices and contests for each team member to insure proper medical treatment in the event of emergency or injury.

Name of Athlete:

Birthdate:

Grade:

Sex:  M  F

Parent's Name(s):

Home Phone:

Work Phone:

Cell Phone:

Email:

Address:

\_\_\_\_\_ *Street*

\_\_\_\_\_ *City*

\_\_\_\_\_ *Zip*

Emergency Contact in the event parents cannot be reached:

\_\_\_\_\_ *Name*

\_\_\_\_\_ *Phone*

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 to any illness or injury resulting from his/her athletic participation.

In the case of an emergency or injury, do you as parent/guardian give permission for school authorities to use their own judgment in contacting 911 and/or ambulance services?

YES

NO

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

Parent/Guardian Signature:

Date:

**ROCK RIDGE PUBLIC SCHOOLS**

**218-744-2211**

**www.rrps.org**