SMI EMERGENCY MEDICAL AUTHORIZATION

This form must be available at all practices and competitions for each member in order to ensure medical treatment by physicians or hospital in the event of serious injury.

PLEASE PRINT OR TYPE

Name of Member: _____

Date of Birth: _____ Sex: _____

Birth Certificate (or) Social Security Number: _____

Parent/Guardian: _____

Address: _____

Home phone: _____ Business Phone: _____

Authorized contact person in event parent/guardian cannot be contacted:

_____ Phone: _____

Does your child have any allergies to foods or medications of which we should be aware? Please list: _____
_____

Does your child have any medical conditions of which we should be aware?
(asthma, diabetes, seizures, etc.) _____
_____

Does your child take any medications/treatments of which we should be aware?
(asthma inhalers, insulin, thyroid meds, antidepressants, etc.) Please list and include dosing schedule: _____

Are there any over-the counter drugs that you **DO NOT** want your child to have?
Please list: _____
_____

If your child becomes ill or injured, do you give the Director or Designee permission to take your child to a doctor or clinic for medical treatment for illness or injury?
Yes_____ No_____

Do you give doctors or nurses permission to treat your child in case of injury or illness?
Yes_____ No_____

Please list any insurance information that your child would need if medical treatment is necessary:

Name of person that insurance is listed under: _____

Group policy name: _____

Group policy number: _____

Insured's policy number: _____

PLEASE ATTACH A COPY OF THEIR MEDICAL INSURANCE CARD <u>AND</u> SEND AN ADEQUATE SUPPLY OF ANY MEDICATIONS NEEDED

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

Preferred physician: _____

Preferred hospital: _____

ALLERGIC TO: _____

I understand this authorization will only be enforced if I/we cannot be contacted and provide immediate treatment.

_____ _____

Parent/Guardian Signature/Date

(This form must be signed and notarized)

Subscribed and Sworn to Before Me this __ __ day of _____, 20 ___.

_____ _____

(Parent/Legal Guardian) **Notary Public**

_____ _____

(Date) **(Date)**