

NAME: \_\_\_\_\_ PHONE \_\_\_\_\_ AGE \_\_\_\_\_ SPORT \_\_\_\_\_  
 Last First MI CITY YEAR IN SCHOOL: FR SO JR SR  
 HOME ADDRESS \_\_\_\_\_ ZIP \_\_\_\_\_

PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_ HOSPITAL \_\_\_\_\_

In case of emergency we will attempt to contact a parent at home or work. If you cannot be reached we will attempt to contact the person listed as the alternate name.

Alternate name: \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examination and immunizations for the above named student. In the event of an emergency arising out serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is unable to communicate with me, the treatment necessary for the best interest of the above-named student may be given. Permission is also granted to the certified athletic trainer to provide the needed emergency treatment to the above-named athlete prior to admission to the medical facilities

\_\_\_\_\_  
 Father's Signature Date

\_\_\_\_\_  
 Mother's Signature Date

\_\_\_\_\_  
 Father's Printed Name

\_\_\_\_\_  
 Mother's Printed Name

\_\_\_\_\_  
 Work Phone Cell Phone

\_\_\_\_\_  
 Work Phone Cell Phone

**Please see reverse side to list medical conditions, allergies, medications, etc.**

ATHLETIC EMERGENCY MEDICAL AUTHORIZATION CARD – Oswego School District 308

**COMMENTS**

ASTHMA/INHALER TYPE	YES	NO	_____
ALLERGIES (please be specific)	YES	NO	_____
LIFE THREATENING DISEASES	YES	NO	_____
GLASSES/CONTACTS	YES	NO	_____
OTHER VISION PROBLEMS	YES	NO	_____
EAR/HEARING PROBLEMS	YES	NO	_____
HEART PROBLEMS	YES	NO	_____
DIABETES	YES	NO	_____
SEIZURES	YES	NO	_____
BLOOD DISORDERS	YES	NO	_____
NEUROLOGICAL PROBLEMS	YES	NO	_____
MUSCULAR PROBLEMS	YES	NO	_____
SERIOUS INJURIES/AGE	YES	NO	_____
HOSPITALIZATION/AGE	YES	NO	_____
SURGERY/AGE	YES	NO	_____
DAILY MEDICATIONS/LIST IF ANY (please be specific)	YES	NO	_____
ADDITIONAL COMMENTS OR DIRECTIONS _____			_____