

# MEDICAL AUTHORIZATION

**RE:** \_\_\_\_\_ (Student's Name) Home Telephone: \_\_\_\_\_  
(Please print)

Address: \_\_\_\_\_ City \_\_\_\_\_ ZIP \_\_\_\_\_

Because I am aware that injury or illness to my son or daughter may result, and in my absence, I here by authorize, by my signature below, any and all emergency medical treatment and/or medication to be administered by any and all hospital, doctor, and/or emergency personnel in order to secure the safety and comfort of my son or daughter. I will also assume full financial responsibility for all medical treatment and/or medication administered by the hospital, doctor, and/or emergency personnel. I understand that I will be notified as soon as possible, and trust and authorize Roger Murphy, Diane Murphy, Alan Lively, or a responsible adult designated by Roger Murphy to make any and all necessary decisions in the event that I cannot be immediately contacted. Because I am also aware that emergency situations require immediate and expert attention, and because I hold the health and well being of my son or daughter as being of utmost importance, I authorize all before named necessities by my signature.

### ***NOTARY WITNESS TO PARENT/GUARDIAN SIGNATURE***

**Signature: Parent /Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**PRINT PARENT NAME** \_\_\_\_\_

State of Ohio, County of \_\_\_\_\_

**The foregoing instrument was acknowledged before me this** \_\_\_\_\_ **day of** \_\_\_\_\_

**by** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
**Notary Public** **My Commission Expires**

### **EMERGENCY CONTACT:**

Parent Phone # 1 \_\_\_\_\_ Phone # 2 \_\_\_\_\_

**List two people to be contacted in the event you cannot be reached.**

NAME \_\_\_\_\_ Phone \_\_\_\_\_

NAME \_\_\_\_\_ Phone \_\_\_\_\_

### **INSURANCE INFORMATION:**

MEDICAL INSURANCE COMPANY \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ Phone 800 \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_

Consumer ID \_\_\_\_\_ Group Policy # \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_

**STUDENT INFORMATION:**

PRINT NAME of Student \_\_\_\_\_

AGE \_\_\_\_\_ Birth date \_\_\_\_\_ Ht. \_\_\_\_\_ Wt. \_\_\_\_\_

Family Doctor's Name \_\_\_\_\_ Phone \_\_\_\_\_

Family Dentist's Name \_\_\_\_\_ Phone \_\_\_\_\_

**PLEASE LIST ANY MEDICAL FACTS: INDICATE NONE IF APPLICABLE**

ALLERGIES: \_\_\_\_\_

MEDICATIONS: \_\_\_\_\_

HEALTH CONCERNS: \_\_\_\_\_

PHYSICAL IMPAIRMENTS: \_\_\_\_\_

LAST TETANUS BOOSTER: \_\_\_\_\_

**Please describe any medical condition including severity and treatment:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**\*\*\*Incomplete or non-returned forms shall result in the student being excluded from participation.**