OVAC EMERGENCY MEDICAL AUTHORIZATION FORM

Athlete's Name _____ School _____
Address _____
City _____ State _____ Zip _____
Telephone (_____) _____ Date of Birth _____

Mother _____ Daytime Phone (_____) _____
Father _____ Daytime Phone (_____) _____
Other Name _____ Daytime Phone (_____) _____

PART I - CONSENT

In the event reasonable attempts to contact me at the above number, or other parent and/or relative, have been unsuccessful, I HEREBY GIVE MY CONSENT for:

1. the administration of any treatment deemed necessary by Doctor or Dentist listed below, or, in the event the designated preferred Doctor/Dentist is not available, by another licensed Doctor/Dentist, and
2. the transfer of the athlete to the hospital listed below or any hospital reasonably accessible.

This authorization DOES NOT cover major surgery unless the medical opinions of two (2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Doctor _____ Phone _____
Dentist _____ Phone _____
Medical Specialist_____ Phone _____
Local Hospital_____ Phone _____

Listed are the facts concerning my son's/daughter's medical history, which include allergies, medications being taken, or any other physical impairments to which a physician should be alerted:

_____
_____
_____
_____

Parent/Guardian Signature _____ Date _____

PART II - REFUSAL TO CONSENT

I DO NOT GIVE MY CONSENT for emergency medical treatment of my son/daughter. In the event of illness or injury requiring emergency treatment, I wish OVAC officials to take the following action: _____

_____
_____
_____
_____

Parent/Guardian Signature _____ Date _____