

MADRID-WADDINGTON CENTRAL SCHOOL
P.O. BOX 67, MADRID, NY 13660
315-322-5746

ATHLETIC DEPARTMENT

Interscholastic Athletic Emergency Information / Authorization Form

This form must be available by the Coach at all team practices and contests for each team member, to ensure proper medical treatment by physicians or hospital in the event of serious injury.

Athlete's Name: _____

Birth Date: _____ Grade: _____ Sex: ____ Male ____ Female

Parents' Name: _____

Home Phone: _____ Business Phone: _____ Cell Ph: _____

Address: _____
(Street) (Town & State) (Zip)

In the event the parents cannot be reached, please contact:

Name: _____ Phone #: _____

List sports the above-named athlete plays:

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

Date of last tetanus shot: _____

Known allergies: _____

Known medical issues: _____

Do you wear contact lenses: ____ Yes ____ No

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

Preferred Physician: _____ Preferred Hospital: _____

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

(Signature of Parent or Guardian)

(Date)