MADRID-WADDINGTON CENTRAL SCHOOL

2582 State Highway 345, Madrid, New York 13660

315-322-5746

Brenda McCall, Athletic Director

Interscholastic Athletic Emergency Information / Authorization Form

This form must be made 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: _____ Date of Birth: _____ Grade: _____

Parents' Names: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email address: _____ Sex: ___ Male ___ Female

Alternate Contact: In the event a parent cannot be reached, please contact:

Name: _____ Relationship: _____ Phone # _____

List sports the above-named athlete plays:

1. _____ 3. _____
2. _____ 4. _____

Date of last tetanus shot: _____

Known allergies: _____

Known medical concerns/issues: _____

_____

Does the athlete 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.

_____ _____

Signed (Parent or Guardian) Date

Please print your name: _____

Rev: Aug 4, 2022