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.**