EMERGENCY MEDICAL AUTHORIZATION FORM

Participant Clearance Package | Complete & Return Before First Practice

■ THIS FORM MUST BE ON SITE AT EVERY PRACTICE AND COMPETITION ■ Athletic Director: Keep original on file. Bring a copy to all events.

SECTION 1 — STUDENT ATHLETE INFORMATION

Last Name:		**First Name:**		**MI:**		**Grade:**	
Date of Birth:		**Age:**		**Gender:**		**Student ID:**	
School:				**Sport(s):**			
Home Address:							
City:			**State:**		**Zip:**		

SECTION 2 — EMERGENCY CONTACTS (List in order of preference)

Contact	Full Name	Relationship	Cell Phone	Home Phone	Work Phone
Parent/Guardian #1					
Parent/Guardian #2					
Emergency Contact #3					

SECTION 3 — HEALTH INSURANCE INFORMATION

Insurance Provider:		**Policy/Group #:**	
Subscriber Name:		**Subscriber DOB:**	
Insurance Phone:		**Member ID:**	

Does athlete have secondary/supplemental athletic insurance? ■ Yes ■ No If Yes, Provider: ___________________________ Policy #: ________________

SECTION 4 — CRITICAL MEDICAL INFORMATION

Known Allergies (food, medication, environmental, bee stings):

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Current Medications (name, dose, frequency):

Known Medical Conditions / Diagnoses:

Physician / Primary Care Provider Name & Phone:

Preferred Hospital / Emergency Room (if applicable):

Does the athlete carry an EpiPen? ■ Yes ■ No **Inhaler?** ■ Yes ■ No **Glucose monitor/insulin?** ■ Yes ■ No

Location of medications during events: ____

SECTION 5 — AUTHORIZATION & CONSENT

I, the undersigned parent/legal guardian, hereby authorize the coaching staff, athletic trainers, and school personnel of the above-named NFMSS-affiliated school to: (1) obtain emergency medical treatment for the above-named student athlete in the event I cannot be reached; (2) authorize transport by ambulance or other emergency vehicle to the nearest appropriate medical facility; and (3) consent to emergency surgical or medical procedures deemed necessary by a licensed physician to preserve the life or health of my child. I understand that school personnel will make every effort to contact me prior to any medical intervention. I release NFMSS, its member schools, and their employees from liability for actions taken in good faith under this authorization.

Parent/Guardian Signature:	______________________	**Date:**	____________________
Printed Name:	______________________	**Relationship to Athlete:**	____________________

For Office Use Only: ■ PPE on file ■ SCA Sign-off on file ■ Heat Sign-off on file ■ Insurance verified ■ Form complete