

School Year _____

MCAS ATHLETICS EMERGENCY MEDICAL AUTHORIZATION

Form # 402

Rev. 3/07

Whenever _____ is involved in a school activity or I am unavailable or otherwise unable to provide authorization directly. I grant to the Michigan City Area Schools' athletic staff the authority to act for me and to provide any required consents for the delivery of emergency medical examination, treatment and transportation, including surgical intervention, and do all other necessary things as I might or could do if I were present.

Parent / Guardian Signature

Authorized _____

Date _____

Parent / Guardian Printed Name

Home Address _____

Home Phone _____ Other Phone _____

Mother's Business Phone _____ Father's Business Phone _____

Student's Birthdate _____ Grade _____ School _____

INSURANCE INFORMATION

Company Name _____

Member Name _____

Identification Number _____ Group Number _____

Phone Number _____

Family Physician _____ Phone Number _____

BRIEF MEDICAL HISTORY

Allergies (including medication) _____

Tetanus (date of last booster) _____

Existing Medical Conditions (diabetes, epilepsy, etc.) _____

----- CUT ON LINE -----

School Year _____

MCAS ATHLETICS EMERGENCY MEDICAL AUTHORIZATION

Form # 402

Rev. 3/07

Whenever _____ is involved in a school activity or I am unavailable or otherwise unable to provide authorization directly. I grant to the Michigan City Area Schools' athletic staff the authority to act for me and to provide any required consents for the delivery of emergency medical examination, treatment and transportation, including surgical intervention, and do all other necessary things as I might or could do if I were present.

Parent / Guardian Signature

Authorized _____

Date _____

Parent / Guardian Printed Name

Home Address _____

Home Phone _____ Other Phone _____

Mother's Business Phone _____ Father's Business Phone _____

Student's Birthdate _____ Grade _____ School _____

INSURANCE INFORMATION

Company Name _____

Member Name _____

Identification Number _____ Group Number _____

Phone Number _____

Family Physician _____ Phone Number _____

BRIEF MEDICAL HISTORY

Allergies (including medication) _____

Tetanus (date of last booster) _____

Existing Medical Conditions (diabetes, epilepsy, etc.) _____

