****FORM MUST BE COMPLETED BY A PHYSICIAN & RETURNED TO HEAD COACH BY FIRST PRACTICE****

EMERGENCY MEDICAL AUTHORIZATION

Physician Statement of Fitness

Child's Name:	Date of Birth:
Address:	Parent/Guardian:
City, Zip	Phone:

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while participating in a Talawanda Bantam Football Association program when parents or guardian cannot be reached.

PARTS I OR II MUST BE COMPLETED

Part I (To Grant Consent)

In the event reasonable attempts to contact me at ______________________________ or
(home)

_________________________ or ___________________________________have been unsuccessful,
(cell) (other parent/guardian & number)

I hereby give my consent for the administration of any treatment deemed necessary by

Dr. ____ or
Physician w/ number

Dr. ____.
(dentist w/ number)

In the event the designated preferred physician or dentist is not available, I agree to have my child treated by another licensed physician

or dentist and the transfer of the child to ____.
(hospital)

Or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Please list any facts concerning the child's medical history including allergies, medication being taken, and physical impairments to which a physician should be alerted:

____

Signature of Parent/Guardian____Date: ___________________

Part II (To Refuse Consent) Do not complete Part II if you have completed Part I

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish no action to be taken.

Signature of Parent/Guardian ____Date: ___________________

PHYSICIAN STATEMENT

I examined the above named child on _____________________and find him/her to be physically fit and able to participate in TBFA football and/or cheerleading. Any medications or known allergies are listed above.

Signature of Physician: _______________________________________ Date:________________________