STARK COUNTY TERRIERS BASEBALL CLUB

EMERGENCY MEDICAL AUTHORIZATION

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under Stark County Terriers authority, when parents or guardians cannot be reached.

Player's Name ______________________ Birth Date ______________ Age of Player ________
Address______________________ City ______________ ZIP______________
Telephone (Home) ______________________ (Cell) ______________________

Residential Parent or Guardian

Mother ______________ Day Ph # ______________ Cell/Pager #______________
Father ______________ Day Ph # ______________ Cell/Pager #______________
Other Name ______________ Day Ph # ______________ Cell /Pager#______________
Other Name ______________ Day Ph # ______________ Cell /Pager#______________

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor______________________ Phone # ______________________
Dentist______________________ Phone # ______________________
Medical Specialist ______________________ Phone # ______________________
Hospital ______________________ Phone # ______________________

Below check any current health condition that may require attention during the school day:

- ❑ Allergies *(be specific)*
  - ❑ Foods ______________________
  - ❑ Medicines______________________
  - ❑ Bee Stings ❑ EpiPen
  - ❑ Other______________________
- ❑ Asthma ❑ Inhaler
- ❑ Cancer
- ❑ Diabetes
- ❑ Hearing problems ❑ Hearing aid(s)
- ❑ Heart problems *(be specific)* ______________________
____
- ❑ Surgeries *(include year)* ______________________
____
____
- ❑ Concussion/head injury *(year)* ______________________
- ❑ Physical disability *(be specific)* ______________________
____
- ❑ Respiratory *(be specific)* ______________________
____
- ❑ Seizures ______________________
- ❑ Vision problems *(be specific)* ______________________
____
- ❑ Glasses ❑ Contacts
- ❑ ADD/ADHD
- ❑ Behavior/emotional problems ______________________
____
- ❑ Other *(be specific)* ______________________
____

List all medications and dosages your child receives on a continual basis:
____
____

***PART A *OR* PART B MUST BE COMPLETED BUT NOT BOTH**

PART A ***TO GRANT CONSENT***

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by the designated physician or dentist, or in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to the designated hospital or any hospital reasonably accessible.

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

Signature of Parent of Guardian ______________________________ Date ______________

PART B ***REFUSAL TO CONSENT***

I do not give consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the authorities to take no actions, or to: ____
____
____

Signature of Parent of Guardian ______________________________ Date ______________