

**EMERGENCY MEDICAL AUTHORIZATION  
HARRISON CO. SCHOOL DISTRICT**

This form must be made available by the coach at all team practices and contests for each team member to insure proper medical treatment by physicians or hospitals in the event of serious injury.

**Athlete's Name** \_\_\_\_\_  
**Birth Date** \_\_\_\_\_ **Grade** \_\_\_\_\_ **Sex** \_\_\_\_\_ **Age** \_\_\_\_\_  
**Parent / Guardian** \_\_\_\_\_  
**Address** \_\_\_\_\_  
**Home #** \_\_\_\_\_ **Work #** \_\_\_\_\_ **Cell #** \_\_\_\_\_

In the event the parent/guardian cannot be contacted, please contact:

\_\_\_\_\_ Phone # \_\_\_\_\_

List sports the above named athlete plays:

\_\_\_\_\_

I hereby give my consent for medical treatment deemed necessary by physicians designated by school authorities and/or for transportation to a hospital emergency room for treatment for any illness or injury resulting from his/her athletic participation.

Preferred Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Preferred Hospital, Gulf Coast Area \_\_\_\_\_

Preferred Hospital, Hattiesburg Area \_\_\_\_\_

I understand this authorization will only be enforced when I cannot personally be contacted and provide for immediate treatment.

\_\_\_\_\_  
Signed By Parent / Guardian

\_\_\_\_\_  
Date