TEAM LINDSEY

TEAM LINDSEY WRESTLING CLUB EMERGENCY MEDICAL AUTHORIZATION

_____
Wrestler's Name

_____ _____
Address *City/Zip*

PURPOSE: To enable parents and guardians to authorize the provisions of emergency treatment for Team Lindsey Youth or SWS Wrestlers who become ill or injured while under the supervision of the Lindsey Trained Wrestling Coaches, when parents or guardians cannot be reached.
Notify Team Lindsey Wrestling immediately if any information changes.
PART I OR PART II MUST BE COMPLETED

PART I - TO GRANT CONSENT

In the event reasonable attempts to contact anyone of the following:

Parent_____ Phone_____
first last home work/cell

Parent_____ Phone_____
first last home work/cell

Step-parent_____ Phone_____
first last home work/cell

Emergency Contact_____ Phone_____
first last home work/cell

have been unsuccessful, I hereby give my consent for: One (1), the administration of any treatment deemed necessary by the preferred physician or dentist, or, in the event the designated practitioner is not available, another licensed physician or dentist; Two (2) the transfer of the child to the preferred hospital or any hospital reasonably accessible; and Three (3), I further give consent to treatment of the child during transportation by the Anderson Twp. Life Squad or other available medical technician ambulance to the below designated doctor/dentist office or hospital.

Preferred Physician_____ _____
phone

Preferred Dentist_____ _____
phone

Preferred Hospital_____

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring the necessity for such surgery, are obtained before surgery is performed.

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted: _____

_____

Date: _____ _____
Signature of Parent/Legal Guardian

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

PART II - REFUSAL TO CONSENT

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 Milford Youth Wrestling Coaches to take the following action: **MUST BE COMPLETED IF REFUSING CONSENT FOR TREATMENT:** _____

_____

Date: _____ _____
Signature of Parent/Legal Guardian: