TEACH

MEDICAL TREATMENT AUTHORIZATION 2018 - 2019

The following is a legal document that will authorize any treatment necessary during the 2018-2019 TEACH sport season. Please read this very carefully and sign in the appropriate places. Make sure that parent or guardians sign for all minors. Fill our one form for each athlete that is participating.

I (We) the undersigned parent(s) or legal guardian(s) of ____
Do hereby authorize and consent to any X-ray examination, anesthetic, medical or surgical diagnosis and treatment rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act; or a dentist licensed under the provision of the Dental Practice Act and on the staff of any acute general hospital holding a current license toe operate a hospital in this state's Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power to render care which the aforementioned physician in the exercise of his/her best judgment may deem advisable. It is understood that effort shall be made to contact the underwritten prior to rendering treatment to the patient, but that any of the above treatments will not be withhold if the undersigned cannot be reached.

____/____/________ ____
Date Father/Guardian Signature

____/____/________ ____
Date Mother/Guardian Signature

MEDICAL HISTORY

Family Doctor's Name ________________________________ Phone ____________________________

Allergic to any medicine:_______ If yes list medicine and any reactions.

Medicine _____________________________________ Reaction _____________________________________

Medicine _____________________________________ Reaction _____________________________________

Allergic to any foods: ________ If yes list food and reaction.

Food ____ Reaction _____________________________________

Food ____ Reaction _____________________________________

Last Tetanus shot date ____/____/_______

Verification of Insurance Coverage
TEACH is not responsible for payment of any medical costs (personal or accidental) that you may incur while participating in this program. Please complete the following section with the appropriate information.

NAME ____________________________________ Insurance Co ______________________________________

Policy/Group No ___________________________ Expiration Date ____/____/_______

I have read the above information and I understand that TEACH is not responsible for my medical expenses ad that I am encouraged to supply my own medical insurance for any TEACH related activity

FATHER/GUARDIAN SIGNATURE _____________________________________ DATE ____/____/_______

MOTHER/GUARDIAN SIGNATURE _____________________________________ DATE ____/____/_______