

MEDICAL TREATMENT AUTHORIZATION 2019 - 2020

T The following is a legal document that will authorize any treatment necessary during the 2019-2020 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.

E I (We) the undersigned parent(s) or legal guardian(s) of

A 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 to 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 undersigned 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 and that I am encouraged to supply my own medical insurance for any TEACH related activity

FATHER/GUARDIAN SIGNATURE _____ DATE ____/____/____

MOTHER/GUARDIAN SIGNATURE _____ DATE ____/____/____