NOTRE DAME ACADEMY EAGLES

3535 SYLVANIA AVE., TOLEDO, OHIO 43623

EMERGENCY MEDICAL AUTHORIZATION

NAME: _____GRADE_____
Last First Middle

STREET ADDRESS:_____

CITY:_____STATE:_____ZIP CODE_____

PHONE NUMBER:_____ CELL PHONE:_____

FAMILY PHYSICIAN: _____PHONE NUMBER:_____

FAMILY DENTIST:_____PHONE NUMBER:_____

PREFERRED HOSPITAL:_____

MEDICAL INSURANCE POLICY HOLDER:_____
(MEDICAL INSURANCE **REQUIRED** TO PARTIICPATE IN ATHLETICS AT NDA)

POLICY NUMBER:_____GROUP NUMBER:_____

ARE THERE ANY HEALTH CONDITIONS THAT WE SHOULD BE MADE AWARE OF- SUCH AS ASTHMA, DIABETES, HEART DISEASE, EPILEPSY OR ALLERGIES?

_____
_____
_____

LIST ANY MEDICATIONS ROUTINELY TAKEN AND WHAT ARE THEY FOR?_____
_____
_____

Sport/Season Your Daughter is Participating In_____

Purpose - To enable parents to authorize emergency treatment for students who become ill or injured while under school authority, when parents cannot be reached.

In the event reasonable attempts to contact me at phone #_____or #_____other parent _____or other authorized person_____ have been unsuccessful, I hereby give my consent for the administration of any medical treatment deemed necessary and/or transfer of the student to the nearest hospital.

This authorization does not cover major surgery unless the medical opinions of two (2) other licensed physicians or dentists, concurring in the necessity for such surgery are obtained before the surgery is performed. Facts concerning the student's medical history, including allergies, medications being taken, and any physical impairment to which a physician should be alerted, should be listed above.

SIGNATURE OF PARENT_____

DATE_____