



# Mission San Jose High School

## Authorization For Emergency Medical Care

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Grade \_\_\_\_\_ Male/Female \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_

Father's Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Name and phone number of another person who is authorized to approve emergency medical treatment:

Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Family Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Health Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_

*This card is to enable parents and guardians to authorize emergency medical treatment for student-athletes who become ill or injured while under school authority, when parents or guardians cannot be contacted.*

Full authorization is given for the administration of any medical treatment deemed necessary by a licensed trainer or medical practitioner and/or the transfer of son/daughter to any licensed hospital or emergency clinic reasonably accessible. 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" on the part of the school authorities to provide reasonable care.

Blood Type \_\_\_\_\_ Allergies \_\_\_\_\_

Last Tetanus Booster \_\_\_\_\_ Allergies to medications \_\_\_\_\_

Any previous significant medical problems \_\_\_\_\_

**Signature of Parent or Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_