

Clearcreek Youth Soccer Association

P.O. Box 341
Springboro, OH 45066

Emergency Medical Form

Parent Name: _____
Last First Middle

Address: _____

Home Telephone: _____ Business Telephone: _____

Child's Name: _____

PURPOSE: To enable parents and guardians to authorize the emergency medical care for children who become ill or injured while under CYSA authority, when parents or guardians cannot be reached.

Part I - Granting Consent

In the event that reasonable attempts to contact me at (phone) _____ or _____ (other parent or guardian) at (phone) _____ have been unsuccessful, I hereby give my consent for (1) the administration of treatment deemed necessary by (preferred physician) _____ at (phone) _____ or (preferred dentist) _____ at (phone) _____, or in the event that the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to (preferred hospital) _____, (hospital phone) _____.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity of such surgery, are obtained prior to the performance of such surgery.

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 or Guardian

Part II - Refusal of Consent

Do Not Complete Part II if you completed Part I

I do not give my consent for emergency medical treatment for my child.

Date

Signature of Parent or Guardian