Hillsdale Academy
Athletic Department
Emergency Medical Authorization

Athlete's Name_____

Birth Date_____Grade_____Gender_____

Parents' Names_____

Address_____

Home Phone_____ Business Phone_____

In the event the person cannot be contacted, pleas contact:

_____at phone #_____

Relationship of above person to the student-athlete_____

List sports the above named athlete will play in the 2007-08 school year:
1._____
2._____
3._____
4._____

I hereby give my consent for medical treatment deemed necessary by physicians designated by school authorities and/or transportation to a hospital emergency room for treatment for any illness or injury resulting from his or her athletic participation.

Preferred physician_____Phone #_____

I understand this authorization will only be enforced when I cannot personally be contacted and provide for immediate treatment.

_____ _____
Signed (Parent or Guardian) Date