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