

Figure Skating Club of Cincinnati

EMERGENCY MEDICAL AUTHORIZATION FORM

Skater's Name _____
Last First MI

Address _____

City, State, ZIP _____

Home Phone _____ Date of Birth: _____

Medical Insurance Company: _____ Phone: _____

Policy Holder's Name: _____ Policy #: _____

Medical Information

Doctor _____ Phone: _____

Dentist _____ Phone: _____

Medical Specialist _____ Phone: _____

Preferred Hospital _____ Emergency Room phone: _____

Facts concerning the skater's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

Primary Emergency Contact - Parent/Guardian/Spouse (if applicable)

Name _____ Relationship _____

Phone _____ Cell/Pager _____

Alternate Emergency Contact

Name _____ Relationship _____

Phone _____ Cell/Pager _____

PART I OR II (not both) MUST BE COMPLETED

PART I: TO GRANT CONSENT

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for:
1) the administration of any treatment deemed necessary by a licensed physician or dentist; and
2) the transfer of myself/my child to any hospital reasonably accessible.
This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Signature of Skater (or Parent/Guardian if under 18)

Date

PART II: REFUSAL TO CONSENT

I do **NOT** give my consent for emergency medical treatment of myself/my child. In the event of illness or injury requiring emergency treatment, I wish the responders to take the following action:

Signature of Skater (or Parent/Guardian if under 18)

Date

