



MID-SOUTH POP WARNER  
EMERGENCY MEDICAL AUTHORIZATION  
2006



Please provide information for your son/daughter:

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Parents Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Family Doctor: \_\_\_\_\_

Preferred Hospital for Treatment: \_\_\_\_\_

**PROVIDE EMERGENCY CONTACT INFORMATION IN THE EVENT WE CANNOT CONTACT YOU:**

Name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_ Phone : \_\_\_\_\_

Name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_ Phone: \_\_\_\_\_

LIST ANY ALLERGIES (Bee Stings, medicine, etc) OR CONDITIONS (asthma, seizures, diabetes, etc.)  
WHICH THE ORGANIZATION SHOULD BE AWARE OF:

\_\_\_\_\_  
\_\_\_\_\_

List any prescribed medication that your child is currently taking:

\_\_\_\_\_  
\_\_\_\_\_

Additional medical information that may be helpful:

\_\_\_\_\_  
\_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

I hereby give my consent for medical treatment deemed necessary by physicians designated by the organization and/or for transportation to a hospital emergency room for the treatment of any illness or injury resulting from his/her athletic participation. I understand this authorization will only be enforced when I cannot personally be contacted and provide for immediate treatment.

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date