DIOCESE OF TUCSON CATHOLIC SCHOOLS
SPORTS LEAGUE

EMERGENCY TREATMENT FORM

Authorization To Treat A Minor

This form will be used only if a parent/guardian cannot be present at a hospital emergency room when your child is in need of treatment. Every reasonable attempt will be made to contact parents, before proceeding to the emergency room.

I/We, the undersigned parent, parents, or legal guardian of the minor below, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general supervision of any licensed member of the medical staff and emergency room staff, or a dentist licensed and on the staff of any acute general hospital holding a current license to operate a hospital from the State of Arizona Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis or treatment of hospital care being required, but is given to provide authority and power to render care which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

This consent shall remain in effect until: _____

_____ _____
Date Signature of Father, Mother, or Legal Guardian

_____ _____ _____
Child's Name DOB School's Name

_____ _____ _____
Father's Name Home Phone Work/Cell Phone

_____ _____ _____
Mother's Name Home Phone Work/Cell Phone

_____ _____ _____
Child's Physician Phone Designated Hospital for Treatment

_____ _____ _____
Insurance Company Phone Policy Number/Group Number

_____ _____
Last Tetanus Booster Please list any allergies to drugs or foods

_____
Please list any medications, restrictions, or special instructions:

_____