

**Santa Monica/Malibu Unified School District
Authorization for Emergency Medical Care (Waiver)**

SPORT(S) Circle all that apply: **No Restrictions** Cross Country Football Golf Tennis Volleyball Water Polo
Basketball Soccer Wrestling Softball Swimming Track & Field Volleyball Pep/Cheer Baseball

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for student athletes who become ill or injured while under school authority when parent or guardian cannot be reasonably reached. Male / Female House _____ Student I.D.# _____ Grade _____

NAME (LAST) _____ (FIRST) _____

ADDRESS (Residence) _____ Age _____ Date of Birth _____

CITY, STATE & ZIP _____ Home Phone _____ Student Cell Phone _____

Parent/Guardian Name _____ Home Phone _____ Work/Cell Phone _____

Parent/Guardian Name _____ Home Phone _____ Work/Cell Phone _____

Family Doctor _____ Phone _____ Family Dentist _____ Phone _____

Health Insurance Co. _____ Policy ID _____ Agent _____ Phone _____

Name and phone number of person other than parent/guardian who is authorized to approve emergency medical treatment:

Name _____ Home Phone _____ Work/Cell Phone _____

IN THE EVENT OF A MEDICAL EMERGENCY, if I cannot be reached, I hereby give consent for my child to be transported to an Emergency facility and to receive attention from a licensed trainer, medical practitioner, physician or dentist.

Allergies _____ Allergies to medication(s) _____ Glasses or contacts? _____

False teeth or bridgework? _____ Last Tetanus booster _____

Any previous significant medical problems? _____

Date _____ Signature of Parent/Guardian _____

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