

Ascent Classical Academy of Northern Denver

Griffin Athletics

**Emergency Medical Authorization/Consent for Treatment**

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| --- | --- | --- |
| Athlete's Name: | Grade: | Date of Birth: |
| Parent(s)/Guardian(s) Name(s): |
| Address: |
| City: | State: | Zip: |
| Phone # (Home) | (Cell/Work) |

In the event none of the above can be contacted please contact:

(Contact Name) at (Phone #)

Relationship to above student athlete:

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 immediate treatment.

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| Printed (Parent/ Guardian) |
| Signed (Parent/ Guardian) |
| Date: |
| **\*\* THIS PAGE MUST BE RETURNED TO YOUR DIRECT COACH \*\*** |