MSO STATE TOURNAMENT MEDICAL EMERGENCY CONTACT INFORMATION

Remember, all decisions regarding treatment will be made after consulting your MSO team's coach.

Emergency Contact and Medical Information

Please complete and sign this form.

______________________________ ___ Male
Child's Last Name, First Name ___ Female

____
Address

____
City, State, Zip Code

This section is to be completed by the MSO Team Coach

____
School Name

____
Coach's Name

____
Coach's Cell Phone
(number to be reached during competition)

____
Parent/Guardian Name

(____)__________ (____)__________
Home Phone Work Phone

(____)________________
Cell Phone

____
Address

____
City, State, Zip Code

____
Parent/Guardian Name

(____)__________ (____)__________
Home Phone Work Phone

(____)________________
Cell Phone

____
Address

____
City, State, Zip Code

Alternative Emergency Contacts

In the event of any medical emergency, attempts will be made to contact the parent(s) /guardian(s) immediately.

____
Primary Emergency Contact

____
Relationship to Child

(____)________________
Home Phone

(____)________________
Cell Phone

(____)________________
Work Phone

____
Address

____
City, State, Zip Code

____
Secondary Emergency Contact (other than parent/guardian)

____
Relationship to Child

(____)________________
Home Phone

(____)________________
Cell Phone

(____)________________
Work Phone

____
Address

____
City, State, Zip Code

This is a two sided form—please fill out both sides.

Medical Information

ALLERGIES ☐ None known at this time

______Medications (please describe)

______

______

______ Food Allergies (please describe)

______

______

______Penicillin ______Bee Stings

______Other (please describe) ______

______

HEALTH HISTORY (check all that apply to your child)

______	Asthma	______	Rheumatic Fever
______	Epilepsy	______	Convulsions
______	Diabetes	______	Heart Condition
______	Other (please describe)		

______

______

______

Current Medications ☐ None at this time

Medication ***Dosage***

______

______

______

______
Family Physician's Name

(______)______
Phone Number

______
Hospital/Clinic/Office

Medical Insurance Information

______
Insurance Company Policy Number / Contract Number

______
Group Number Plan Code

Authorization / Permission

I acknowledge the information listed here is accurate and **give permission to my child's MSO team coach (listed on first page) to authorize the appropriate treatment in the best interest of my child's welfare**.

______ ______ ______
Parent's/Guardian's Signature Parent's/Guardian's Name Printed Date

I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.

______ ______
Parent's/Guardian's Signature Parent's/Guardian's Name Printed Date

To protect your confidentiality this form will be shredded after the tournament

This is a two sided form—please fill out both sides.