



CAPITAL HOMESCHOOL ATHLETIC PROGRAM

Emergency Authorization Form

Athlete's Name: _____ Athlete's Birthdate: _____

Parent's Name(s): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone 1: _____

Email: _____ Cell 2/Pager: _____

Father's Place of Employment: _____

Work Phone: _____

Mother's Place of Employment: _____

Work Phone: _____

Other People that can be reached in case of emergency:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Hospital Preference: _____

Insurance Company: _____ Policy/Contract No: _____

Group Number: _____ Service Code: _____

Medications Allergic to: _____

Medical Information we should be aware of: _____

I hereby give permission for my above-named minor child to receive emergency medical and/or surgical treatment and/or transport. Non-emergency medical treatment or elective surgery is not included in this authorization.

Signature: _____ Date: _____