

**Pickens County School Athletics:**  
**Emergency Medical Authorization**

\_\_\_\_\_  
Student's Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Grade

\_\_\_\_\_  
Address

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Emergency Telephone #

\_\_\_\_\_  
Parent's/Guardian's Name

\_\_\_\_\_  
Alternate Person

\_\_\_\_\_  
Alternate's Telephone #

*Purpose: To enable parents to authorize emergency treatment for children who become ill or injured under school authority when parents cannot be reached*

**Part I or II Must be Completed**

**Part I-TO GRANT CONSENT**

In the event reasonable attempts to contact me(**parent's name**)\_\_\_\_\_ at  
(**Phone #**)\_\_\_\_\_ or (**alternate person's name**)\_\_\_\_\_  
at (**alternate person's #**)\_\_\_\_\_ have been unsuccessful, I hereby give  
my consent to any member of the coaching staff of any treatment deemed necessary. I also grant  
consent to the coaches to transfer my child to Piedmont Mountainside Hospital or any hospital  
reasonably accessible and to provide said hospital with any and all medical information necessary  
for treatment. This authorization does not cover major surgery unless the medical opinions or 2  
other licensed physicians concurring in the necessity for such surgery are obtained before surgery  
is performed.

Facts concerning the child's medical history including allergies, medications being taken and any  
physical impairment to which a physician should be alerted:\_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

(Continued on opposite side)

*(Do not complete if you completed Part I)*

**Part II-REFUSAL TO CONSENT**

I do not give my consent for emergency treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the coaches to take no action. If I cannot be contacted, I wish the coaches to take no action or to: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date