

AUTHORIZATION FOR MEDICAL TREATMENT

**This form must be kept with the team manager at all times!!!!!!**

Texas Destination Imagination and East Region

(East Regional Tournament and Affiliate Tournament, Mansfield, Texas )

Student Name \_\_\_\_\_ Age \_\_\_\_\_

Parent / Guardian \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_, TX Zip \_\_\_\_\_

Phone: Home (    ) \_\_\_\_\_ Business/Cell (    ) \_\_\_\_\_

In case of emergency, if parent /guardian cannot be reached, please contact:

Name \_\_\_\_\_ Phone (    ) \_\_\_\_\_

Email \_\_\_\_\_ Cell phone(    ) \_\_\_\_\_

Please list any medical information that should be known and/or regular medication that the student is taking or is necessary for any condition:

Every effort will be made to contact the parent or guardian of the student prior to any unusual medical treatment. The undersigned parent or guardian of the student named hereon agrees that in the event of emergency illness or injury, that a licensed emergency response team or MD shall be authorized to administer medical or surgical treatment deemed necessary for the treatment of the student.

\_\_\_\_\_ Date \_\_\_\_\_

(Signature of parent or guardian authorizing treatment)

Name of insurance company \_\_\_\_\_

Policy/Group number \_\_\_\_\_

Place of employment issuing insurance \_\_\_\_\_

Verification telephone number (from back of card) \_\_\_\_\_