

# Delhi Athletic Association Emergency Medical Form

Player's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Father: \_\_\_\_\_ Phone: H \_\_\_\_\_ W \_\_\_\_\_ C \_\_\_\_\_

Mother: \_\_\_\_\_ Phone: H \_\_\_\_\_ W \_\_\_\_\_ C \_\_\_\_\_

Back-up (Friend, neighbor, relative)

Name: \_\_\_\_\_ Phone: H \_\_\_\_\_ W \_\_\_\_\_ C \_\_\_\_\_

Dr.'s Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Dr.'s Address: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist's Address: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

Medical Insurance Name: \_\_\_\_\_ Policy #: \_\_\_\_\_

Medical Condition(s) coaches should be aware of (asthma, diabetes, etc.): \_\_\_\_\_

Allergies (food, medicines, bee stings, etc.): \_\_\_\_\_

*In the event of an emergency and any of the individuals listed above can not be located, I hereby give the coaching staff of DAA authorization to use their best judgment on administering first aid or/and transporting named player to the appropriate medical facility. At the medical facility if no contact has been established with any of the individuals listed above to proceed with treatment based on the opinion of two concurring physicians.*

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

*I do not authorize any medical treatment to be attempted in the event the individuals listed above can not be located. Instead, I prescribe the following action:*

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

*(Signature of one parent or guardian is the signature for all parents or guardians)*