Livonia Warriors

Emergency Medical Authorization

Consent for Medical/Surgical Care, Emergency Treatment, and Student Medical Information

PERSONAL CONTACT INFORMATION

Student Name		Date of Birth	
Street Address		Phone	
City		Zip	
Primary Contact		Cell Phone	
Employer		Work Phone	
Secondary Contact		Cell Phone	
Employer		Work Phone	

STUDENT MEDICAL INFORMATION

Physician Name		Phone	
Known Allergies		Date of Last Tetanus Booster	
Medications			
Other Health Conditions/Concerns			

MEDICAL INSURANCE INFORMATION

Name of Insured		Date of Birth	
Insurance Carrier		Policy Number	
Phone		Group Number	
Preferred Hospital		City	

EMERGENCY CONTACT INFORMATION

Name		Relationship	
Primary Phone		Secondary Phone	

I, _____, as a parent or legal guardian of the above-named student, hereby give my consent to Isolina D. Carlini of Livonia Public Schools, or assigned representative in possession of the original form, to arrange for medical, surgical, and/or dental care and treatment necessary to preserve the health of my child. I acknowledge that I am responsible for all reasonable charges in connection with care and treatment rendered during the period from the date of this authorization until June 30, 2016.

I have read this form and I certify that I understand its contents.

Signed _____ Date _____