



**2017 EASTERN ZONE DIVERSITY SELECT CAMP AND REGIONAL COACHES CLINIC
MEDICAL AUTHORIZATION FORM**

Date(s): June 15-18, 2017 Athlete Name: _____

Camp: 2017 Eastern Zone Diversity Select Camps and Regional Coaches Clinic

I do hereby voluntarily consent to clinic care including routine diagnostic procedures, medical and /or surgical treatment by the physician facility chosen by him/her for (athlete name) _____

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantee is to be made to me as to the result of the treatments or examinations by these persons or facilities.

Signature of Parent/Guardian

Date

PLEASE INCLUDE TELEPHONE NUMBERS WHERE A RELATIVE OR GUARDIAN CAN BE REACHED IN CASE OF AN EMERGENCY.

Parent (1):	AM Phone:
Cell:	PM Phone:
Parent (2):	AM Phone:
Cell:	PM Phone:
Emergency Contact:	AM Phone:
Cell:	PM Phone:
Physician:	Phone:
Dentist:	Phone:
Medical Insurance:	Policy #:

Medical Authorization Form (continued)

Allergies: Is there a history of skin or other untoward reaction or sickness following injection or oral administration of:

(a) Penicillin or other antibiotics	Yes	No
(b) Morphine, Codeine, Demerol (narcotics)	Yes	No
(c) Novocain or other anesthetics	Yes	No
(d) Aspirin, Emperin, other pain remedies	Yes	No
(e) Sulfa Drugs	Yes	No
(f) Tetanus, antitoxin or other serums	Yes	No
(g) Adhesive Tape	Yes	No
(h) Iodine or Methiolate	Yes	No
(i) Any other drug or medication	Yes	No
(j) Any foods (eggs, milk, chocolate, etc)	Yes	No
(k) Insect bites, bee stings other	Yes	No
(l) Other _____	Yes	No

Drugs taken recently: Within the last six months has the athlete taken-

(a) Cortisone	Yes	No
(b) ACTH	Yes	No
(c) Anticoagulants	Yes	No
(d) Tranquilizers	Yes	No
(e) Hypotensives (high blood pressure medicine)	Yes	No

Has the athlete ever received treatment for:

(a) Asthma/ Rheumatism, Rheumatic Fever	Yes	No
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Any other physical conditions of which we should be aware of:
