Big Foot Wolves Medical Authorization Form

Name of Participant:_____

Health History:

CONDITION	YES	NO
Kidney Injuries		
Heart Condition or Disease		
Diabetes		
Asthma		
Glasses		
Contacts		
Concussion: If Yes when was last one:		
Allergic to Medications: If Yes what is child allergic to:		

Emergency Contact Name:

Emergency Contact Number:

Insurance Carrier:

Doctor's Name and Phone Number:

Parent/Guardian Signature_____

Dated: _____

In the event of an emergency requiring medical attention, I hereby grant permission to a physician or other hospital personnel designated by the Big Foot Wolves, Inc. coaching staff to attend my son/ daughter:

I expect every effort will be made to contact me in order to receive my specific authorization before any treatment or hospitalization is undertaken