AUTHORIZATION FOR MEDICAL TREATMENT

<u>This form must be kept with the team manager at all times!!!!!!</u>

Texas Destination Imagination

Capital Region Tournament: February 29, 2020 – Connelly High School

LONE STAR FINALS: UNVERSITY OF TEXAS AT ARLINGTON APRIL 3-4, 2020

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) _____