

UNIVERSITY  WISCONSIN  
MARATHON COUNTY

Athletics

AUTHORIZATION FOR EMERGENCY TRANSPORTATION AND TREATMENT

Participant's Information:

Name _____	/ /	/ /	/ /	/ /	
First	Initial	Last	Date of birth	Age	
Address _____					
Street	City	Zip	Phone Number	Sex	

Parent or Guardian's Information

Name _____	/ /	/ /	/ /	/ /	
First	Initial	Last	Date of birth	Age	
Address _____					
Street	City	Zip	Phone Number	Sex	

Relative or Friend Information:

Name _____	/ /	/ /	/ /	/ /	
First	Initial	Last	Date of birth	Age	
Address _____					
Street	City	Zip	Phone Number	Sex	

Personal Physician

Name \_\_\_\_\_ Phone # \_\_\_\_\_

I do \_\_\_\_\_ do not \_\_\_\_\_ Authorize school personnel to transport me to a physician's office and/or emergency room in the event that emergency medical care is needed.

I do \_\_\_\_\_ do not \_\_\_\_\_ Authorize physician and hospital staff to treat me as they deem necessary in the emergency situation.

PERSONAL INFORMATION

1. Name of medical insurance company: \_\_\_\_\_
2. Policy number of medical insurance: \_\_\_\_\_
3. Do you have any medical limitations (i.e. allergies, asthma, diabetes) or are you on any medications?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, list: \_\_\_\_\_

Signature of Athlete/Assistant \_\_\_\_\_ Date \_\_\_\_\_  
(or parent/guardian if student is under age 18)

**NOTE:** This authorization will assure that you will receive emergency medical treatment in a timely manner. This form will be kept on file with the team coach/manager or advisor.