

**HARDIN COUNTY SPECIAL OLYMPICS
EMERGENCY MEDICAL AUTHORIZATION/INFORMATION**

Date _____ Individual's Name _____

Social Security Number _____ Date of Birth _____

Street Address, City, Zip Code _____

Home Telephone Number _____

Name of Parents or Guardians _____

Parents/Guardians Cell Numbers _____ OR _____

Parents/Guardians Place of Employment _____

Work Phone _____ ext. _____

May his/her name or photo appear in news releases? _____ Yes _____ No

Facts concerning individual's medical history that the physician should be alerted to:

Any kind of allergies? _____

Specific Medical Problems: _____

Medication (include non-prescription medication and dosages):

Does the individual have a current "Do Not Resuscitate" order _____ Yes _____ No
(If so, please attach a copy to this form)

Blood Type: _____

Medicaid Number: _____

Name of Local Physician: _____

Address: _____ Office Phone: _____

Name of Local Dentist: _____

Address: _____ Office Phone: _____

There may be times when we need to contact you because of illness or some other reason. In the event that we cannot reach you, please provide us with the names and phone numbers of two (2) people we can contact.

Name _____ Phone _____

Name _____ Phone _____

PART I OR II MUST BE COMPLETED

PART I

In the event that _____ (individual) experiences a life-threatening injury at a Special Olympics event, I acknowledge that he/she will be transported immediately to Hardin Memorial Hospital (or nearest hospital) and efforts will be made to contact me immediately.

Further, I acknowledge that should _____ (individual) experience an injury that requires medical attention that is not life-threatening, all efforts will be made to notify me immediately. If I, or someone else, can not get to the Special Olympics Event within 15 minutes of the accident, Hardin County Special Olympics will ensure that the individual is transported to Hardin Memorial Hospital (or to nearest hospital).

In the event that reasonable attempts have been made to contact us (parents) at the above telephone numbers but are unsuccessful, I hereby give consent to:

Dr. _____ (preferred doctor)

Dr. _____ (preferred dentist)

Or in the event the designated preferred practitioner is not available, another licensed physician or dentist may administer the necessary treatment to the individual.

Signature of Parent/Guardian/Individual

PART II

In the event of illness or injury requiring emergency treatment I authorize Hardin County Special Olympics to take no action or to:

Signature of Parent/Guardian/Individual: _____