Findlay Silver Blades
Figure Skating Club
FINDLAY, OHIO

2024-2025 EMERGENCY MEDICAL AUTHORIZATION

The Emergency Medical Authorization provides parents/guardians the option to authorize the provision of emergency treatment for a skater who becomes ill or injured while under club authority and the parents/guardians and other provided contacts cannot be reached.

SKATER INFORMATION

Full Name Printed _____ DOB _____

Address _____

City _____ State _____ Zip _____

Please list any facts concerning the skater's medical history including allergies, medical conditions, medications being taken and physical impairments our Board of Directors, coaches and/or physicians need to be alerted too.

_____

_____

_____

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_____

Are the skater's biological parents divorced, separated or neither has custody? *(circle one)* Yes No

If Yes, who is the residential parent/custodian? *(circle one)* Mother Father Shared Other

Please list any special circumstances, i.e. custody arrangements, financial agreements, etc. the Board of Directors and/or Coaches need to be aware of?

_____

_____

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_____

CONTINUED

2024-2025 EMERGENCY MEDICAL AUTHORIZATION *(continued)*

GRANT CONSENT FOR MEDICAL TREATMENT

EMERGENCY CONTACT LIST

CONTACT ORDER	RELATIONSHIP (Mother, Father, Guardian, Grandparent, Sitter, etc.)	NAME	CELL PHONE NUMBER
1 (*)			
2 (*)			
3			
4			
5			
6			
7			
8			

MEDICAL CONTACT LIST

SPECIALITY (Orthopedic, Pulmonologist, etc.)	NAME	PHONE NUMBER
Family Doctor (*)		
Family Dentist (*)		

In the event the designated preferred physician or dentist is not available; I hereby give consent for treatment by any licensed physician or dentist. ***(circle one)*** **Yes No**

I hereby give consent to allow my child to be transported by Emergency Medical Services to the hospital listed or any hospital accessible. ***(circle one)*** **Yes No Hospital** _____

I affirm that I am the parent/guardian of the skater listed above and I hereby GIVE CONSENT for the administration of any treatment deemed necessary by the above health care professionals. This authorization does NOT cover major surgery unless the medical opinion of two other licensed physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Parent/Guardian Full Name Printed _____

Parent/Guardian Signature _____ Date _____

(*) Required Information

CONTINUED

2024-2025 EMERGENCY MEDICAL AUTHORIZATION *(continued)*

REFUSE CONSENT FOR MEDICAL TREATMENT

I affirm that I am the parent/guardian of the skater listed above and I hereby REFUSE CONSENT for the emergency medical or dental treatment of my child.

In the event of illness or injury requiring emergency treatment, I wish the club authorities to: ***(circle one)*** **(*)**

Take No Action **Take the Action Explained Below**

Take ONLY the following action in the event of illness or injury requiring emergency medical or dental treatment:

_____

_____

_____

_____

_____

Parent/Guardian Full Name Printed _____

Parent/Guardian Signature _____ Date _____

(*) Required Information