# Ascent Classical Academy Douglas County

Guardians Athletics

Emergency Medical Authorization/Consent for Treatment

Athlete's Name: ____________________________________________

Birth Date: ________________ Grade: __________________

Parent(s)/Guardian(s) Name(s):__________________________________

Address: _______________________________________________

Phone # (Home) ______________________ (Cell/Work)____________________

In the event none of the above can be contacted please contact:

__________________________________ at (Phone number)________________

Relationship to above student athlete: ____________________________

I hereby give my consent for medical treatment deemed necessary by physicians designated by school authorities and/or transportation to a hospital emergency room for treatment for any illness or injury resulting from his or her athletic participation.

Prefered Physician: _______________________________

Phone #: _____________________________________

I understand this authorization will only be enforced when I cannot personally be contacted and provide for immediate treatment.

__________________________________________ ____________________

Signed (Parent/Guardian) Date

** THIS PAGE MUST BE RETURNED TO YOUR DIRECT COACH **