**Malone Central School District**
**Department of Athletics**
**Authorization for Medical Treatment of Minors**

______________________________________ ___________________________
**NAME OF MINOR** **BIRTH DATE**

___________________________________________________________________
**ALLERGIES OR SPECIAL CONDITIONS**

___________________________________________________________________
**LIST ALL CURRENT MEDICATION CHILD IS TAKING**

**I, BEING THE PARENT OR LEGAL GUARDIAN OF THE ABOVE NAMED MINOR, DO HEREBY APPOINT ONE OF THE FOLLOWING INDIVIDUALS TO ACT ON MY BEHALF IN AUTHORIZING UNEXPECTED MEDICAL, DENTAL, SURGICAL CARE AND HOSPITALIZATION FOR THE ABOVE NAMED MINOR.**
**(Attach a copy of driver's license if available):**

___________________________________________________________________________________
**NAME** **ADDRESS** **ZIP** **PHONE #**

___________________________________________________________________________________
**NAME** **ADDRESS** **ZIP** **PHONE #**

**THIS DOCUMENT SHALL BE PRESENTED TO A PHYSICIAN, DENTIST, OR APPROPRIATE HOSPITAL REPRESENTATIVE AT SUCH TIME AS UNEXPECTED MEDICAL, DENTAL, SURGICAL CARE OR HOSPITALIZATION MAY BE REQUIRED.**

_____________________________________________________
**PARENT/GUARDIAN SIGNATURE**

_____________________________________________________
**ADDRESS**

_________________________________
**STATE/ZIP**

__________ ______________
**DATE** **HOME PHONE #**

______________ ______________
**WORK PHONE #** **CELL PHONE #**
**(IF AVAILABLE)**

**HOSPITALIZATION COVERAGE FOR THE ABOVE NAMED MINOR**

__________________________________________________________
**INSURANCE COMPANY OR GOVERNMENT PROGRAM (INCLUDE A COPY OF THE INSURANCE CARD IF AVAILABLE)**

__________________________________
**ID OR CONTRACT NUMBER**

__________________________________
**FAMILY PHYSICIAN NAME**

__________________________________
**FAMILY PHYSICIAN PHONE #**