

MEDICAL TREATMENT AUTHORIZATION

(This form must be signed and turned in to the Emerson Athletic Compliance Office)

I authorize physicians employed by Emerson College or engaged by the College to provide medical care to me while I am participating in _____ [name sport(s)], including examinations, treatments and prescription of medications for my care. I understand that Emerson will, to the greatest extent possible, consult with me concerning the reasons for and effects of all such care. In the event that I may be incapacitated and in situations in which the physicians treating me believe that beginning treatment is medically necessary, I authorize Emerson College to act on my behalf to authorize the physicians providing care to me to commence treatment even if I have not yet been consulted. In authorizing such emergency treatment, I agree to accept the determination of the treating physician or surgeon that the treatment of examination rendered was medically necessary to protect my life, health or mental well-being. I give this consent with the understanding that, if I am incapacitated, Emerson College will make all reasonable efforts to contact my next of kin and that Emerson College will only exercise the power granted by this consent in the event that it is unable to contact my next of kin.

Names and Telephone Numbers of Next of Kin (emergency contact):

Allergies:

Medications currently taking:

I am entitled to medical insurance benefits under a policy with:

[Print name of medical insurer/HMO]

[Medical insurance policy #]

Signature of Student-Athlete Participant

Date