**Medical Authorization Form**

**Gulf Coast District & Area III FFA**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone:

Age: \_\_\_\_\_\_\_ Address:

 Street City Zip

Parent/Guardian Name(s):

Father’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:

Mother’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:

Family Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:

Name of person to contact is parent/guardian is unavailable:

 Name Relationship Phone

List any medication you are currently taking:

List any known medical problems or allergies:

Medical Insurance Company Name:

Name of Insured:

Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number:

“In case of serious illness or accident, I request that the activity sponsors contact me. If I cannot be reached, I authorize contact of the physician above. If it is not possible to contact the physician, I authorize the teacher/advisor to arrange for all necessary medical services for said child on my behalf.”

Signature:

 Parent/Guardian

Date: