



# COLUMBUS EAGLES FC

## EMERGENCY MEDICAL AUTHORIZATION FORM

Player Name: \_\_\_\_\_

Effective date: \_\_\_\_\_

### Emergency medical contacts

Primary

Secondary

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Relationship: \_\_\_\_\_

### Known Medical Conditions

Please list any conditions, medications, allergies, etc. that our medical staff needs to be aware of in the event that you are injured and need medical attention:

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I hereby authorize the Columbus Eagles FC and any of their staff to contact and discuss medical issues related to my participation in any club activity with the contacts noted above in the event that I am unable to do so personally.

Signed: \_\_\_\_\_