GWINNETT MASTERS SPECIAL TEAMS
220 Bayswater Drive
Suwanee GA 30024
Phone: 404-625-3988
Fax: 1-866-231-6432

AUTHORIZATION for MEDICATION

Date:_____

Athlete's Name:_____

Self-Medicate_____ **Need Adult to Medicate**_____ **Not on Any Medications**_____

I authorize a representative of Gwinnett Masters Special Teams to administer or monitor the above named athlete's medication needs on a daily basis while away at a GMST event. I understand that the representative is not a trained medical provider. I understand the representative will follow all directions given on the prescription label and verbal or written directions from me. I authorize the representative to seek medical advice if needed. I understand the representative will keep written documentation of all medical information and that I can request a copy of this.

I authorize a representative of GMST to secure medical care in case of an emergency. I understand 911 may be called and that I will be held responsible for payment of any medical expenses.

I authorize a representative of GMST to administer basic first aid for minor issues. This may include, but not be limited to, band-aids, antibiotic creams, ice packs, etc. Please check the following if your athlete may be given the following over the counter medications.

_____**Tylenol** _____**Ibuprofen** _____**Benadryl** _____**Antacids** **Other**_____

_____ _____

Parent/Guardian/Caregiver Signature **Athlete Signature**

Parent/Guardian/Caregiver Contact Information

Name:_____ Relationship:_____

Home Phone:_____ Cell:_____ Work Phone:_____

Other Emergency Contact (Must be available 24/7)

Should this emergency contact be called before the above parent/guardian/caregiver? _____Yes _____No

Name:_____ Relationship:_____

Home Phone:_____ Cell:_____ Work Phone:_____

Medical Information

Athlete's Medical Conditions (Example: Down syndrome, autism, asthma, diabetes, etc.) are: _____

_____

_____

Any Allergies:_____ Type:_____ Drug Allergies:_____

Any Seizures:_____ Type:_____ Describe Seizure Protocol:_____

_____

Insurance Provider:_____ Name of Insured:_____

Policy Number:_____ Group Number:_____

Other medical or dietary information:_____