Authorization-Consent for Treatment and Emergency Contact

I/we understand that my son/daughter/ward,
Legibly print name of student: _____

Last name **First** **MI**

Please choose and initial **ONE (1) LINE** in this section:

_____ (Please initial) knows of and acknowledges the risk involved and potential injuries that may occur in athletic participation, understands that serious injury, and even death, is possible in such participation, and choose to accept any and all responsibility for his/her safety and welfare while participating in athletics. I/we hereby grant permission to the team physician(s) and certified athletic trainers(s) to administer any preventative, first aid or emergency treatments that he/she deem reasonably necessary to the health and well-being of my student athlete. The coaching staff of the school and or the host athletic trainer will provide care. I/we understand the certified athletic trainer(s) may offer my student advice concerning injury prevention, care, flexibility, nutrition, hydration and other general conditioning principles. I/we further authorize emergency medical treatment while he/she is under the supervision of the school. This form and the other Athletic Medical Information Forms may be reproduced to travel with respective teams and is acceptable for emergency treatment if needed.

_____ (Please initial) WILL NOT grant permission to the team physicians(s) and certified athletic trainer(s) to administer any preventative or rehabilitative treatment, nor other general conditioning advice. Further clarification of a "NO" response is requested with the Athletic Director regarding First Aid and Emergency Care Guidelines to be arranged.

EMERGENCY CONTACT INFORMATION

PRIMARY CONTACT: (1)

_____

Name Relationship Home Phone Cell/Work Phone

_____

Street Address City State Zip Code

SECONDARY CONTACT: (2)

_____

Name Relationship Home Phone Cell/Work Phone

_____

Street Address City State Zip Code

Primary Care Physician: _____ **Phone**: _____

Preferred Local Hospital or Emergency Room: _____

Check here if **NO** preference: _____ **NOTE**: In the case of a life-threatening condition (particularly away from the local area), the closet emergency room will be utilized.

_____

The patient must sign authorization. If the patient is a minor or is an incompetent adult, their guardian must sign authorization. If there is no guardian appointed by the court, the authorization must be signed by the nearest relative. If the patient is unable to sign this authorization, please state the reason:_____

_____ _____

Signature of student **Date** **Signature of Parent or Guardian** **Date**

_____

Home Address City State Zip Code

_____

Home Phone Work/Cell Phone

_____

Witness Signature **Date**