

CONSENT FOR ATHLETIC TRAINING SERVICES and EMERGENCY MEDICAL  
TREATMENT

(Must be completed and signed by the athlete's parent or guardian.)

RETURN TO THE \_\_\_\_\_

Students' Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Student's Address \_\_\_\_\_ City \_\_\_\_\_

Student's Social Security Number \_\_\_\_\_

Parent (Guardian) Name \_\_\_\_\_

Home Phone \_\_\_\_\_

Father: Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Mother: Work Form \_\_\_\_\_ Cell \_\_\_\_\_

In case of an emergency and absence of parent/guardian; please list two people you  
recommend we call:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

List any known allergies \_\_\_\_\_

List any medications the student is taking \_\_\_\_\_

List any physical disabilities \_\_\_\_\_

Additional comments \_\_\_\_\_

Name of Medical Insurance Company of Plan \_\_\_\_\_

Policy numbers \_\_\_\_\_

Health Maintenance Organization (HMO)? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what is your primary facility \_\_\_\_\_

**Consent & Authorization**

I hereby authorize the employed or contracted staff of the \_\_\_\_\_ High School  
Athletic Department ("Department")(i.e., coaches, athletic trainers, team physician,  
and/or other assigned medical personnel) to provide athletic training services to my  
son/daughter/ward and to secure and medical assistance on behalf of my  
son/daughter/ward. I further authorize these individuals to discuss my  
son/daughter/ward's medical condition with other health care personnel, which the  
Department deems appropriate. To the fullest extent permitted by law, I do hereby  
Indemnify and hold harmless the Department, entities, and other persons who act in  
reliance upon this authorization.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_