

ATHLETIC EMERGENCY/CONSENT TO TREAT



Athlete's Name: \_\_\_\_\_

Circle One: Male Female Grade: 9 10 11 12

Sport(s): Fall \_\_\_\_\_ Winter \_\_\_\_\_ Spring \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Parent/Guardian Cell Phone Number: \_\_\_\_\_

Name of another adult we could call in case of emergency: \_\_\_\_\_ Phone #: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_ Insurance Phone #: \_\_\_\_\_

Insurance Policy #: \_\_\_\_\_

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

Please list any known conditions or allergies that the coaches or athletic trainer need to be aware of:

- (1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_
(4) \_\_\_\_\_ (5) \_\_\_\_\_ (6) \_\_\_\_\_

In consideration of my child's opportunity to participate in interscholastic activities, I hereby consent to emergency medical treatment, hospitalization or other medical treatment as may be necessary for the welfare of my child, by a physician, qualified nurse, certified athletic trainer, and/or hospital in the event of injury or illness during all periods of time in which the student is away from his/her legal residence as a member of an interscholastic activity team or group, and hereby waive on behalf of myself and my child any liability of the school district, any agents or employees, arising out of such medical treatment.



Signature of Parent/Guardian

Date

CARD #1 FOR COACHING STAFF

ATHLETIC EMERGENCY/CONSENT TO TREAT



Athlete's Name: \_\_\_\_\_

Circle One: Male Female Grade: 9 10 11 12

Sport(s): Fall \_\_\_\_\_ Winter \_\_\_\_\_ Spring \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Parent/Guardian Cell Phone Number: \_\_\_\_\_

Name of another adult we could call in case of emergency: \_\_\_\_\_ Phone #: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_ Insurance Phone #: \_\_\_\_\_

Insurance Policy #: \_\_\_\_\_

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

Please list any known conditions or allergies that the coaches or athletic trainer need to be aware of:

- (1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_
(4) \_\_\_\_\_ (5) \_\_\_\_\_ (6) \_\_\_\_\_

In consideration of my child's opportunity to participate in interscholastic activities, I hereby consent to emergency medical treatment, hospitalization or other medical treatment as may be necessary for the welfare of my child, by a physician, qualified nurse, certified athletic trainer, and/or hospital in the event of injury or illness during all periods of time in which the student is away from his/her legal residence as a member of an interscholastic activity team or group, and hereby waive on behalf of myself and my child any liability of the school district, any agents or employees, arising out of such medical treatment.



Signature of Parent/Guardian

Date

CARD #2 FOR ATHLETIC TRAINER