

# SHS EMERGENCY TREATMENT MEDICAL CONSENT FOR ATHLETICS

*Please print all information:*

Athlete's LAST Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ 2009-2010 Grade in School - (Circle one) 9 10 11 12

Permission is hereby granted to the attending physician to proceed with any minor surgical treatments, x-ray examination, and immunizations for the above named student in the event of serious illness or injury or the need for major surgery. I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, the treatment necessary for the best interest of the above named student may be given. Permission is also given for the athletic trainer and/or other school representatives to provide the needed emergency first aid treatment to the student prior to his/her admission to a medical facility.

Printed Name of Parent/Guardian: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Parent's Home Phone: \_\_\_\_\_

Father's Cell Phone: \_\_\_\_\_

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

Mother's Cell Phone: \_\_\_\_\_

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

Physician's Name: \_\_\_\_\_

Physician's Phone: \_\_\_\_\_

Emergency contacts if unable to reach parents:

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

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

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

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

Does your Child have medical problems: (List):

\_\_\_\_\_  
\_\_\_\_\_

Does your Child have allergies (List):

\_\_\_\_\_

Does your Child take routine medications: (List)

\_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

Sports your student intends to participate:

Fall: \_\_\_\_\_ Winter: \_\_\_\_\_ Spring: \_\_\_\_\_