

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: _____