



# Franciscan HEALTH

## SPORTS MEDICINE

### MEDICAL TREATMENT CONSENT FORM

I hereby give permission, in the event of an accident, injury, or illness, for any and all necessary medical care to be administered to my child, \_\_\_\_\_, under the direction of the Licensed Athletic Trainer employed by Franciscan Health Sports Medicine, until such time as I may be contacted. This release is effective for the time during which my child is participating in the athletic program for the **2023/24** school year, including official practices and travel to and from the competition site. I also hereby assume responsibility for payment resulting from such treatment. In addition, I release the Licensed Athletic Trainer to provide the appropriate coaching staff, team physician, family physician, physical therapist, and other medical personnel with medical information that may affect my child's ability to participate in athletics or may be needed to provide the athlete with medical care.

Athlete's Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Gender: Male Female

Graduation Year: \_\_\_\_\_ Sport(s): \_\_\_\_\_

Athlete's Allergies: \_\_\_\_\_

Medical History (major illness, hospitalization, injury): \_\_\_\_\_

Medications athlete currently uses: \_\_\_\_\_

Specific Injuries due to athletics: \_\_\_\_\_

Name of Parent or Guardian: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Pager or Cell Phone: \_\_\_\_\_

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

Emergency contact (grandparent, aunt, uncle, sibling over 18 years old, etc.) who parent or guardian designates to authorize emergency medical care if parent or guardian not available:

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

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

Health Insurance Company: \_\_\_\_\_ Policy or ID #: \_\_\_\_\_

Hospital Preference 1st: \_\_\_\_\_ 2nd: \_\_\_\_\_

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

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_