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): ____

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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: _______________________

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