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 **2024/25** 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: _____