MEDICAL CONSENT FORM

LAST NAME _____ FIRST NAME_____

Current School Year:_____

Grade:_____ Date of Birth_____ Age:_____

Sport(s):_____

Parent/Guardian Name:_____

Parent Contact #:_____

2nd Parent/Guardian Name:_____

2nd Parent Contact#:_____

Insurance Company_____ Group #_____

History of Migraines? Yes___ No____ Asthma? Yes___ No____

Heart Conditions? Yes__ No___ If yes, what_____

Diabetes? Yes___ No___ Other:_____

Allergies:_____

Current Medications:_____

Permission is hereby granted to the athletic trainer, team physician, or school staff to administer first aid treatment for the above student-athlete. I also give permission for the athletic trainer, team physician, coaches, and support staff to communicate about the above named student-athlete's injuries, unless a written request is made to the athletic department. In the event of serious illness or injury, it is understood that every attempt will be made to contact me. If contact cannot be made with me, I do consent in advance to any treatment necessary for the best interest of the above named student athlete.

_____ _____

Signature of parent/guardian Date