

**CONSENT FOR ATHLETIC TRAINING SERVICES and  
EMERGENCY MEDICAL TREATMENT**  
*(Must be completed and signed by the athlete's parent or guardian)*

Student's Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Student's Address \_\_\_\_\_ City: \_\_\_\_\_

Parent (Guardian) Name: \_\_\_\_\_

Home Phone \_\_\_\_\_

Father: Work Phone \_\_\_\_\_ Cell: \_\_\_\_\_

Mother: Work Phone \_\_\_\_\_ Cell: \_\_\_\_\_

In case of emergency and the absence of parent/guardian, please list two people you recommend we call:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

List any known allergies: \_\_\_\_\_

List any medications student is taking: \_\_\_\_\_

List any physical disabilities: \_\_\_\_\_

Additional Comments: \_\_\_\_\_

Name of Medical Insurance Company or Plan: \_\_\_\_\_

Policy Numbers: \_\_\_\_\_

Health Maintenance Organization (HMO)? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what is your primary care facility: \_\_\_\_\_

**CONSENT & AUTHORIZATION**

I hereby authorize the employed or contracted staff of the Shorewood High School Athletic Department ("Department") (i.e., coaches, athletic trainers, team physician, and/or other assigned medical personnel) to provide athletic training services to my son/daughter and to secure any necessary medical assistance on behalf of my son/daughter. I further authorize these individuals to discuss my son/daughter medical condition with other health care personnel, which the Department deems appropriate. To the fullest extent permitted by law, I do hereby indemnify and hold harmless the Department, entities, and other persons who act in reliance upon this authorization.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_