

**SALINE AREA SCHOOLS
MEDICAL CONSENT FORM**

Athlete: _____ Parent/Guardian (1) _____
Last First Middle (print name)

Address: _____ (2) _____
Birth Date: _____

City/Zip: _____

Phone numbers where Parent/Guardian can be reached:

Parent (1) _____ : Work _____ Home _____ Other _____

Parent (2) _____ : Work _____ Home _____ Other _____

Physician's Name: _____ Phone #: _____

Nearest Relative: _____ Phone #: _____

Relation to Athlete: _____

Health Insurance Company: _____

Health Insurance #: _____

HEALTH HISTORY

Kidney Injuries	Yes / No	While competing do you wear:
Heart Disease	Yes / No	Glasses . . . Yes / No
Diabetes	Yes / No	Contacts . . Yes / No
Asthma	Yes / No	(Any circled <u>yes</u> should be briefly explained) _____

Allergies to medication (list): _____

Date of last Tetanus Shot: _____

Other Allergies: _____

Additional Health History: _____

In an emergency, or in case of illness or injury, I hereby give permission for my child to be examined and treated by the athletic trainer and, if necessary, be transported to a physician's office or hospital. I also give permission to the selected licensed physician or hospital to perform diagnostic tests, hospitalize, secure proper treatment, anesthetize, or perform surgery for my child. I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If the physician is not able to communicate with me, I hereby give permission for treatment for the above named athlete. Parent/Guardian Signatures:

(1) _____ (2) _____

This is a legal document. Take it to the hospital and present it to the physician, dentist, or hospital representative so treatment can be given.

Print Date: _____