

### Informed Consent Form

I hereby give my permission for \_\_\_\_\_ to participate in \_\_\_\_\_ during the athletic season beginning in \_\_\_\_\_. Further, I authorize the school to provide emergency treatment of any injury or illness my child may experience if qualified medical personnel consider treatment necessary and perform the treatment. This authorization is granted only if I cannot be reached and a reasonable effort has been made to do so.

Date \_\_\_\_\_ Parent or guardian \_\_\_\_\_

Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Cell phone ( ) \_\_\_\_\_ Beeper number ( ) \_\_\_\_\_

Family physician \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Medical conditions (e.g., allergies or chronic illnesses) \_\_\_\_\_

Other person to contact in case of emergency \_\_\_\_\_

Relationship with person \_\_\_\_\_ Phone ( ) \_\_\_\_\_

My child and I are aware that participating in \_\_\_\_\_ is a potentially hazardous activity. We assume all risks associated with participation in this sport, including, but not limited to, falls, contact with other participants, the effects of the weather, traffic, and other reasonable risk conditions associated with the sport. All such risks to my child are known and appreciated by my child and me.

We understand this informed consent form and agree to its conditions.

Child's signature \_\_\_\_\_ Date \_\_\_\_\_

Parent's or guardian's signature \_\_\_\_\_ Date \_\_\_\_\_

### Emergency Information Card

Athlete's name \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Sport \_\_\_\_\_

List two persons to contact in case of emergency:

Parent's or guardian's name \_\_\_\_\_ Home phone \_\_\_\_\_

Address \_\_\_\_\_ Work phone \_\_\_\_\_

Second person's name \_\_\_\_\_ Home phone \_\_\_\_\_

Address \_\_\_\_\_ Work phone \_\_\_\_\_

Relationship to athlete \_\_\_\_\_

Insurance co. \_\_\_\_\_ Policy no. \_\_\_\_\_

Physician's name \_\_\_\_\_ Phone \_\_\_\_\_

Are you allergic to any drugs? \_\_\_\_\_ If so, what? \_\_\_\_\_

Do you have any allergies (e.g., bee stings or dust)? \_\_\_\_\_

Do you have \_\_\_\_\_ asthma, \_\_\_\_\_ diabetes, or \_\_\_\_\_ epilepsy? (Check any that apply)

Do you take any medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

Do you wear contact lenses? \_\_\_\_\_

Other \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_