CONSENT TO TREAT AND EMERGENCY FORM

International School of Indiana

STUDENT INFORMATION:

Athlete Name _____ Date of Birth _____

Grade _____ Home Phone: _____

Address _____

PARENTS INFORMATION:

Mothers Name _____ Fathers Name _____

Address _____ Address _____

_____ _____

Home Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

EMERGENCY CONTACT: In case we are unable to reach a parent, please provide an alternative emergency contact.

Name _____ Phone Number _____

INSURANCE INFORMATION:

Policy Holder _____ Policy Holders Date of Birth _____

Insurance Company _____ Employer _____

Policy ID Number _____ Group Number _____

Family Physician _____ Does your insurance require a referral? YES/NO

ATHLETE MEDICAL HISTORY:

Does your athlete have any allergies? Yes / No: If yes, please list _____

Will the athlete need to take medications during the season? Yes /No: If yes, please list _____

_____

Does the athlete have any special medical conditions that I need to be aware of? Yes / No: If yes, please list

_____

In the event that an athletic injury or illness should occur to the above named student athlete while participating in a sanctioned athletic activity for International School of Indiana. I give my permission for the student athlete to receive proper/necessary care from a certified / licensed athletic trainer, physician, or other health care individual representing Select Medical Outpatient Division. Furthermore, in the event that a medical emergency should occur and I cannot be contacted, I give my permission for a Select Medical health representative and/or International School of Indiana representative to arrange for ambulance service to the nearest medical facility. I also give permission for the staff of the medical facility to render treatment, which is considered necessary, for the athlete's well-being and health.

Parent/Guardian Signature _____ **Date:** _____