

MEDICAL CONSENT—AUTHORIZATION TO TREAT

To: Any Physician or Hospital

STUDENT ATHLETE NAME: _____ **GRADE** _____

This is to authorize, empower, and direct you to treat the above-named person to such an extent as you shall deem reasonably necessary under the circumstances as they appear to you. We, the parent(s) or guardian(s), consent to such treatment and severely obligate ourselves to pay the reasonable charges therefore.

Permission is also granted to the coach and/or athletic trainer to provide the needed emergency treatment to the student-athlete prior to his/her admission to the medical facilities.

The word "treat" shall include any and all medical, surgical, osteopathic, nursing, diagnostic, and any other procedures including major and minor surgery generally accepted by the medical or osteopathic profession.

I understand that every attempt will be made by the attending physician or hospital to contact me in the most expeditious way possible. If said physician or hospital is not able to communicate with me, the treatment necessary for the best interest of the above-names student may be given. To the best of my knowledge, the following information is correct:

Person to notify in our absence _____ Phone _____

Medical Insurance _____ Policy# _____ Blood Type (if known) _____

Known Allergies _____ Family Physician _____ Phone _____

Medications student is presently on _____ Religion _____

Parent/Guardian Signature _____ Date _____

Home Phone _____ Work Phone _____

OPTIONAL PERMISSION TO DISPENSE ACETAMINOPHEN AND/OR IBUPROFEN **TO STUDENT-ATHLETES**

I, _____, give my child's coach permission to give Acetaminophen (Tylenol) and/or Ibuprofen in the event of my child developing a headache, menstrual cramps, fever, or sprain. I indemnify the North Branch Area Schools, their employees and/or coach in the event that a problem arises from such dispensing.

STUDENT-ATHLETE'S NAME: _____ Grade _____

PARENT SIGNATURE: _____ Phone _____