Athletic Participation/Permission Form

I, the undersigned, am the parent/legal guardian of_____,
(Student-Athlete Name - please print)
a minor and student-athlete at _____who plans on
(Name of School)
participating in_____.
(Sport(s))

I, hereby give consent for a Certified Athletic Trainer, Certified Nurse Practitioner, Certified Physician Assistant or Physician, an employee of St. Francis Physician Practices, LLC ("Practice Personnel") who is contracted by the School, to provide sports medicine and/or athletic training services for the above referenced Student-Athlete. Sports medicine athletic training services include, but are not limited to: administrating first aide for athletic injuries; providing initial treatment and management of acute injuries; and assessing athletic injuries at the request of the athlete, the athlete's coach, or the athlete's parent/guardian. The Practice Personnel will perform only those services that are within their training and scope of professional practice to prevent, care for, and rehabilitate athletic injuries of the Student- Athlete. I understand that as a result of the medical evaluation provided by the Practice Personnel, the Student-Athlete may be transported to a hospital emergency department for further treatment.

1 understand that there is no charge to me for the above listed athletic training services. If the Student- Athlete is in need of further treatment by a physician, or of rehabilitation services for the injury, he or she may see the physician or provider of his/her choice. Injured Student-Athletes that have seen a physician **must submit** written clearance from that physician to the School and/or Practice Personnel prior to being permitted to resume athletic activity. This Authorization shall remain in effect for one sports season beginning with the date set forth below.

Parent/Guardian Name (Print) - _____

Parent/Guardian (Signature) _____ Date_____

Student-Athlete's Emergency Contact _____

Relationship to student athlete_____ Cell/Work phone_____

Home Address_____ Home phone _____

Student Athlete Name_____ Sex_____

Student Athlete Date of Birth_____ Allergies_____

Current Medications (i.e. asthma inhalers, epi-pen, etc.) _____

Physical impairments_____

Other pertinent medical history (surgeries, diabetes, seizures, heart condition, etc.)

_____

Grade_____

Physician Name_____

Physician Phone_____

Medication Release Form

In an attempt to better serve the Student-Athletes at Brookstone School we will have several over the counter oral medications available in the Athletic Training Room. Please review the medications listed below and initial next to each one the Student-Athlete may receive.

Student Name _____

Allergies_____

_____Acetaminophen 500mg- 1 tablet per package

_____Ibuprofen 200mg- 2 tablets per package

_____Mediproxen 220mg- 1 tablet per package

_____Benadryl Allery Ultratabs 25mg- 1 tablet per package

_____Diamode 2mg- 1 tablet per package (equivalent to Immodium)

_____Diotame 262mg- 2 tablets per package (equivalent to Pepto Bismal)

_____Medi-Lyte Electrolytes- 2 tablets per package

PARENTAL CONSENT AND WAIVER

I hereby give my permission for my child _____(please print)
in the_____ grade at Brookstone School to take the above initialed over the counter medications from the Athletic Training Room.

WAIVER OF LIABILITY

I, hereby give consent for a Certified Athletic Trainer, Certified Nurse Practitioner, Certified Physician Assistant or Physician, an employee of St. Francis Physician Practices, LLC (“Practice Personnel") who is contracted by the School to provide the above named Student-Athlete with only the medications initialed above. I hereby waive any and all claims against the school or Practice Personnel and agree to hold the school and Practice Personnel harmless from any and all liability, which may arise in connection with my child’s use of the medication.

Parent or Guardian’s Signature_____Date_____