

Athletic Participation/Permission Form

I, the undersigned, am the parent/legal guardian of _____
(Student-Athlete Name – please print)

a minor and student-athlete at BROOKSTONE SCHOOL

(Name of School) who plans on participating in _____
(Sport(s))

I hereby give consent for a Certified Athletic Trainer, Certified Nurse Practitioner, Certified Physician Assistant, or Physician (“Practice Personnel”) 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: administering first aid 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.

I 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/Wk 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 _____