HOLT HIGH SCHOOL SPORTSMEDICINE
CONSENT FOR EMERGENCY TREATMENT

_____ _____

Athlete's Name **Athlete's Grade (as of today's date)**

Address **City** **State** **Zip Code**

_____ _____ _____

Home Phone # **Today's Date** **Athlete's Date of Birth**

_____ _____

Father's Name **Mother's Name**

_____ _____

Address, If Different From Above **Address, If Different From Above**

_____ _____

Employer **Employer**

_____ _____

Employer Address **Employer Address**

_____ _____

Work Phone # **Work Phone #**

_____ _____

Cellular Phone # **Cellular Phone #**

Insurance Company _____**Policy #**_____**Group#**_____

EMERGENCY CONTACTS:

1. _____
2. _____
3. _____

Name **Address** **City** **Phone#** **Relation**

Form continued on opposite side. →→→→→→→→→→→→→

PLEASE LIST ANY/ALL ALLERGIES

(i.e. medications, insect bites/stings, foods, etc.)

PLEASE LIST ANY/ALL MEDICAL PROBLEMS

(i.e. heart murmur, diabetes, one pupil dilated, multiple concussions, asthma, etc.)

Medications Currently Using _____

Holt High School, and its medical staff, has my/our permission to seek necessary emergency treatment for my daughter/son, _____, during her/his participation in athletic contests, practices and conditioning workouts. I/We also grant permission to the medical staff of Holt High School to discuss matters pertaining to my daughter/son's health/injury status to and/or amongst the coaching staff of my child's athletic team to allow for safe participation in her/his sport. This permission remains in effect during the current academic/athletic year as dated below.

_____

Parent/Guardian Initial Here

_____	_____	_____	_____
Father's Signature	**Date**	**Mother's Signature**	**Date**
_____	_____	_____	_____
Athlete's Signature	**Date**	**Athletic Trainer's Signature**	**Date**

THE SOLE PURPOSE OF THE INFORMATION PROVIDED HERE IS TO BE ABLE TO TREAT THE STUDENT ATHLETES OF HOLT HIGH SCHOOL IN A SAFE AND TIMELY MANNER IN THE ABSENCE OF A PARENT. THANK YOU FOR TAKING THE TIME TO FILL THIS FORM OUT TO THE BEST OF YOUR ABILITY.