

UNIVERSITY HIGH SCHOOL STUDENT ATHLETE INFORMATION

EMERGENCY CONTACT INFORMATION: CONSENT TO TREAT

STUDENT ATHLETE INFORMATION:

Name Date of Birth Grade Sport(s)

PARENT(S) GUARDIAN INFORMATION:

Last Name _____ First _____ MI _____

Street Address _____ City/State _____ Zip _____

Home Phone # () _____ Work Phone # () _____ Mobile # () _____

Spouse's Name and Address if different from above

Home Phone # () _____ Work Phone # () _____ Mobile # () _____

Medical Insurance Company: _____

Policy # _____ Group# _____

Preferred Hospital Network: _____

IN AN EMERGENCY, IF PARENTS/GUARDIANS CANNOT BE CONTACTED:

Contact Name _____ Contact Phone # () _____

Relation to Athlete _____

Primary Care Physician _____ Doctor's Phone # () _____

List Known Allergies (If Any)

List Current Medications (If Any)

Consent is hereby granted to Riverview Health Sports Medicine to initiate any medical or first aid treatment for the above-named student athlete in the event of a significant accidental injury or illness. I understand that an attempt will be made to contact me in the most expeditious manner possible. If in that event I cannot be reached, the treatment necessary for the best interest of the above-named student athlete may be initiated. I have read the above statements and I hereby give my written consent. I have also been offered a copy of Riverview Health's Notice of Privacy Practices.

NOTE: IF THE STUDENT IS UNDER 18 YEARS OF AGE, THIS CONSENT MUST BE SIGNED BY A PARENT OR LEGAL GUARDIAN TO BE VALID. IF THE STUDENT IS 18 YEARS OF AGE OR OVER, THE STUDENT MUST SIGN THIS CONSENT PERSONALLY.

Signature

Print Name and Relationship to Student (if Signed by Parent or Guardian)

THE STUDENT SHALL NOT BE CLEARED TO PARTICPATE IN INTERSCHOLASTIC ATHLETICS UNTIL THIS FORM HAS BEEN SIGNED AND RETURNED TO THE SCHOOL.