

Marshall High School
Emergency Information

Name _____ Birthdate _____

Age _____ Parent/Guardian's Name _____

Home Phone _____ Address _____

Grade _____ Father's Phone _____ Mother's Phone _____

Phone # During Day _____

In case of emergency, if parents cannot be contacted:

Notify _____ Phone _____

Family Doctor _____ Doctor's Phone _____

Preferred Hospital _____ Allergies _____

While competing, do you wear contacts? _____ Use an Inhaler? _____

Use an epi-pen? _____

The team physician, athletic trainer, coach may apply first aid treatment until the family doctor can be contacted. YES _____ NO _____

We give our consent for coaches, athletic trainers, and team physician to use their own judgment in securing medical aid and ambulance service in case the parents cannot be reached.

YES _____ NO _____

We give our consent for the physician, athletic trainer, and coach to discuss relevant and necessary information regarding my son or daughter's sports related injury as it pertains to their ability to perform and or participate. YES _____ NO _____

Date _____ Signature of parent or guardian _____

This information will be kept on file in the team's medical kit in case of emergency. Any information contained on this card will be kept confidential. If you do not wish to give your consent to the last three statements, please give a phone number where we could reach you at all times. _____

My signature is evidence that I have read the Marshall Athletic Code and understand all information contained therein. Please fill out this entire form. Thank You.

Signature of student

Date

Signature of parent / guardian

Date

SPORT _____

**MARSHALL HIGH SCHOOL CONSENT
EMERGENCY TREATMENT FORM**

DATE _____

I, _____, being the parent or legal guardian of _____ give my permission for emergency medical and surgical treatment of this minor in the event that such treatment becomes necessary. I grant my permission for treatment in a licensed hospital by a licensed physician and the physician's assistants and designees including such hospital personnel as the physician may deem necessary. I understand that hospital personnel will make reasonable attempts to contact me before initiating treatment. I am aware that the practice of medicine is not an exact science and that no guarantees can be made concerning the results of treatment.

The minor named in this consent may receive all treatment provided according to generally accepted standards of medical practice with the following limitations (if none, write "none"):
_____.

Signature of Parent or Legal Guardian: _____

Chronic or existing medical conditions or problems (e.g. diabetes, epilepsy):

List medicines your child is now taking:

