

# Athletic Emergency Information/Consent to Treat Card

This card must be filed every year before participation can begin in any athletic program.

Student Athlete's Last Name: \_\_\_\_\_ Student Athlete's First Name: \_\_\_\_\_

Grade: \_\_\_\_\_ Male / Female Student Athlete's Birthdate (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_

Sport Participating In: \_\_\_\_\_  
Fall Winter Spring

1. I hereby give my permission for the above named student athlete to practice and compete and represent the school in WIAA approved sport.
2. I also attest to the fact that the above named student athlete has had no injury or illness serious enough to warrant a medical evaluation prior to participating this school year.
3. I further grant permission for any medical records pertaining to the health of the above named student athlete be made available as necessary to the proper school district personnel and appropriate health care provider, including emergency medical personnel.

Parent: If there is any question that this student may not be qualified for athletic competition without, at least, a partial re-evaluation, contact your medical advisor before signing this card.

\_\_\_\_\_  
Signature of Parent / Legal Guardian

\_\_\_\_\_  
Date

## Emergency Information

Father's Name: \_\_\_\_\_ Father's Contact Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Mother's Contact Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Home Address: \_\_\_\_\_

Parent Email Address: \_\_\_\_\_

Student Athlete's Primary Care Physician: \_\_\_\_\_

Primary Care Physician Contact Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy/Group Number: \_\_\_\_\_

Allergies/Allergic Reactions: \_\_\_\_\_

Known Medical Conditions: \_\_\_\_\_

*In case of an emergency and either parent cannot be reach, please contact the alternate listed below:*

Alternate Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship: \_\_\_\_\_

PERMISSION IS HEREBY GRANTED TO THE ATTENDING PHYSICIAN TO PROCEED WITH ANY MEDICAL TREATMENT. I UNDERSTAND THAT AN ATTEMPT WILL BE MADE BY THE ATTENDING PHYSICIAN TO CONTACT ME IN THE MOST EXPEDITIOUS WAY POSSIBLE. PERMISSION IS ALSO GRANTED TO THE ATHLETIC TRAINER TO PROVIDE THE NEEDED EMERGENCY TREATMENT TO THE ATHLETE PRIOR TO HIS/HER ADMISSION TO THE MEDICAL FACILITIES.

\_\_\_\_\_  
Signature of Parent / Legal Guardian

\_\_\_\_\_  
Date