

Medical Consent Form

Athlete's Last Name: _____ First: _____

Permission is hereby granted to the athletic trainer, team physician, or school staff to administer first aid treatment for the above named student athlete. I also give permission for the athletic trainer, treating physician, athletic director, coaches and school support staff to communicate among each other about the above named student athlete's injuries for the student's benefit, unless a written request is made to the athletic department. In the event of serious illness or injury, it is understood that every attempt will be made to contact me. If contact cannot be made with me, I do consent in advance to any treatment necessary for the best interest of the above named student athlete.

SIGNATURE OF PARENT OR GUARDIAN

DATE

Emergency Contact Numbers

Father/Guardian: _____ Home: _____

Office: _____ Other: _____

Mother/Guardian: _____ Home: _____

Office: _____ Other: _____

Closest Relative: _____ Home: _____

Family Physician: _____ Phone No. _____

Insurance Company: _____ Policy No. _____

Western High School

Health History

Athlete's Name: _____ Grade: _____

NO YES If Yes, Explain

Heart condition or disease _____

Diabetes _____

Asthma _____

Inhaler Use _____

Bee Sting Allergy _____

Epi-Pen Use _____

Any other known medical conditions or problems for the above named athlete: _____

Allergy to any medications: _____

Current Medications: _____