***\*\* Please complete and return to Athletic Office before tryouts\*\****

Emergency Treatment Card

Athlete Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sport(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grade (circle one): Frosh Soph Junior Senior Cell Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2nd Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weight: \_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Co: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Family Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_

**Glasses** (circle): Yes No **Previous Concussion** (circle): Yes No # of \_\_\_\_\_\_\_

**Asthma** (circle): Yes No

**Allergies** (circle): Yes No **List**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

After a reasonable attempt to contact the above named parent/guardian, we, the undersigned to hereby consent any duly authorized member of the high school athletic staff including athletic director, athletic trainer, or coaches to make decisions regarding the transport and or treatment of the above named athlete to an appropriate medical facility. Each of the undersigned attest to above listed information is, to the best of his/her knowledge true and current. Furthermore, each of the undersigned expressly acknowledge and agree that they have read and understood the terms of this form containing an emergency medical authorization and that no oral representations, statements, or inducements apart from the foregoing written provisions have been made.

**Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Athlete (over 18 years old)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_**

**Permission / Release Form**

I give my permission for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to participate as a member of the Shelton High School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ team(s).

I have read and understand the information in this document, as well as the ImPACT program terms of use, and have discussed the athletic rules and regulations with my child. I hereby acknowledge that I am aware that as a result of participation in athletic activity, the above named student may suffer a catastrophic injury. Notwithstanding such warnings and with full knowledge and understanding of the risk involved, I give permission for my child to participate in the activity indicated above.

I also give my consent for any photos which are taken of my child during any game or practice to be posted on the Shelton High School Athletic Department website and/or to be used in publications of the Shelton High School Athletic Department. These photos will only be used for that purpose and not for any commercial purpose.



\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Parent/Guardian Signature of Student**

**\*\*\*MORE INFORMATION ON BACK\*\*\***

Athlete Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consent to Treat

In the event that an athletic injury or illness should occur to the above named student-athlete while participating in a sanctioned athletic activity at Shelton High School, I give my permission for the student-athlete to receive proper/necessary care from a certified/licensed athletic trainer, physician, or other health care individual. Furthermore, in the event that a medical emergency should occur and I cannot be contacted, I give my permission for a certified/licensed athletic trainer, physician, or other health care individual to arrange for ambulance service to the nearest medical facility. I also give permission for the staff of the medical facility to render treatment, which is considered necessary, for the student-athlete’s well being and health.

**Parent/Guardian Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(The student shall not participate in sports without completed consent to treat form on file.)

Concussion Education Plan & Consent Form

I have read and understand the document “Student/Parent – Concussion Education Plan & Consent Form” and understand the severities associated with concussions and the need for immediate treatment of such injuries.

Student name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Print name)

**Student Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Print name)

**Parent/Guardian signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

June, 2014