ALLEN ISD Athlete Emergency Information

(Please Print Except for Signatures)

Parent / Guardian Consent to Treatment of Student-Athlete

This consent to treat is intended to cover any illness or injury sustained while participating in any school athletic competition or practice, on or off campus, and while traveling to and from the event.

I, ______________________________ (Name of Parent), the undersigned parent / guardian of ______________________________ (Name of Student) a minor, do hereby authorize any Allen ISD athletic trainer, coach, or school representative on my behalf to consent to any medical treatment deemed necessary by any licensed physician / surgeon in the event of illness or injury to the above named minor.

If, in the judgment of any representative of the school, the above named student needs immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given to said student by any physician, athletic trainer, nurse, hospital, or school representative; and I do hereby agree to indemnify and save harmless the school and any school representative from any claim by any person whomsoever on account of such care and treatment of said student. I hereby authorize any hospital, which has provided treatment to the above named student to surrender custody of that student to the athletic trainer or school representative upon completion of treatment.

These authorizations shall remain effective until the end of the 2014 / 2015 school year.

X ______________________________ PARENT/GUARDIAN SIGNATURE ______________ DATE

Athlete Emergency Care/Contact Information

(Please Print Except for Signatures)

Athlete Name: ______________________ Date of Birth: ______________ Grade: ________

Parent/Guardian: (Father) ______________________ (Mother) ______________________

Father's Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Mother's Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Home Address: ______________ City: ______________ State: TX Zip: ______________

Name of person living **close by** who can be contacted in case of emergency:

Name: ______________ Relation: ______________ Phone: ______________

PRIVATE (PRIMARY) INSURANCE

Insurance Company Name: ______________________ Pre-Authorization Phone # ______________

Insurance Company Address: ______________________________

City: ______________ State: ______________ Zip Code: ______________

Name of Insured: ______________________________

Group #: ______________ Policy #: ______________ Other #: ______________

HEALTH HISTORY

Asthma: ☐ Yes ☐ No Diabetes: ☐ Yes ☐ No Seizures: ☐ Yes ☐ No

Other Medical Conditions: ______________________________

Known Allergies (drug,food,insect,etc) ______________________________

Medications Currently Taking (inhaler, insulin,etc): ______________________________