Authorization for Emergency Transportation and Treatment

Name____

(Last) (First) (MI) (Grade)

Activities________________________ Birth date_________________

I authorize school personnel to transport my son/daughter to a physician's office and/or emergency room for treatment in the event medical care is needed while he/she is involved in either co-curricular or extra-curricular activities. Further, I authorize the Physician and Hospital Staff to treat my son/daughter as they deem necessary in the emergency situation.

Insurance Company______________________________ Ins #____________________

Medications presently taking____

Known Allergies____

Father's full name________________________________Employment_____________

Home #_________________ Work #________________ Emergency #_____________

Mother's full name_______________________________ Employment_____________

Home #_________________ Work #________________ Emergency #_____________

Family Doctor___________________________________Phone #_________________

Family Dentist___________________________________ Phone #_________________

Return to Athletic Office

PARENT-ATHLETE RULES OF ELIGIBILITY SIGN-OFF FORM – 2016-2017

I certify that I have read, understand, and agree to abide by all of the information contained in this packet - Code for Athletes, WIAA Eligibility information, and the Concussion laws and procedures. I further certify that if I have understood any information contained in these documents, and, if necessary have sought and received an explanation of the information prior to signing this statement.

____
School Name

____ ________________________________
Parent/Guardian's Signature Date

____ ________________________________
Student-Athlete's Signature Date

This form must be completed and submitted to the Athletic Office prior to a student being declared eligible to practice and compete.

(SEASON PASS ORDER FORM ON REVERSE SIDE)