

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 – 2013-2014

I certify that I have read, understand, and agree to abide by all of the information contained in this packet - Code for Athletes, Cautionary Statement, 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.