EMERGENCY CARD/ATHLETIC TRAINER AUTHORIZATION

Students Name_____ Birthdate_____ Gr __ Age___

Address _____ City, State, Zip_____

Sports: Fall_____ Winter_____ Spring_____

Parent/Guardian Name_____ Email _____

Home#_____ Work# _____ Cell#_____

Parent/Guardian Name _____ Email_____

Home#_____ Work#_____Cell#_____

Emergency Contact_____

Relationship to Student_____ Phone#_____

Family Physician_____ Hospital_____

Phone#_____ Phone#_____

Please list any Medical Conditions and / or Injuries that the trainer should know:

_____

This school staffs a certified and registered athletic trainer through the Fairview Health Services Institute for Athletic Medicine for the purposes of educating student-athletes and preventing and treating injuries to student-athletes while participating in school-related athletic events and programs.

I consent to the athletic trainer treating injuries and discussing any injuries or medical conditions with coaches, school staff and other qualified health care providers as deemed necessary within their scope of practice.

I understand that in the case of injury or illness requiring transportation to a health care facility, every attempt will be made to contact me but that, if necessary, the student-athlete will be transported via ambulance to the nearest hospital.

_____ _____ _____

PATIENT OR LEGAL REPRESENTATIVE **LEGAL RELATIONSHIP** **DATE**

Note: This consent must be signed by the patient, unless the patient is a minor child, mentally or physically unable to sign.

REASON PATIENT IS UNABLE TO SIGN □ Minor □ Disability □ Other_____

Updated 6/2013