NorthWood Sports Medicine
Student-Athlete Information & Consent to Treat Form

STUDENT'S NAME-LAST:______________________________ FIRST:__________________________ MI:_______
GRAD YEAR:_________ BIRTH DATE:________________ SPORT(S):____________________________________
ADDRESS:____
CITY:_____________________________ STATE:________ COUNTY:_________________ ZIP:_______________
MOTHER'S/LEGAL GUARDIAN NAME: LAST:________________________________FIRST:___________________
MOTHER'S/LEGAL GUARDIAN PHONE:______________________(home/cell)___________________________(work)
MOTHER'S/LEGAL GUARDIAN EMAIL:____
FATHER'S/LEGAL GUARDIAN NAME: LAST:________________________________FIRST:____________________
FATHER'S/LEGAL GUARDIAN PHONE:______________________(home/cell)_____________________________(work)
FATHER'S/LEGAL GUARDIAN EMAIL:____
LIVES WITH:____
FAMILY DOCTOR:____ PHONE:________________________________
INSURANCE COMPANY NAME:____ POLICY #:___________________

_____**YES** **I/We DO** authorize the evaluation and/or treatment of my/our student athlete by the NorthWood Team Physician and/or Athletic Trainer.

_____**NO** **I /We DO NOT** authorize the evaluation and/or treatment of my/our student athlete by the NorthWood Team Physician and/or Athletic Trainer.

I/We,____, provide consent to any NorthWood Athletic Department Official (Team Physician, Athletic Trainer, or Coach) to provide any emergency medical treatment or forward said treatment to a medical facility in the event that said patient/athlete sustains a life-threatening or serious injury while participating under his/her directions. Every attempt will be made to clear any treatments of serious injuries with the parents first. HOWEVER, in the case of serious LIFE THREATENING injury, where emergency medical treatment is necessary immediately and contact with the parent is not possible, **I DO CONSENT THAT ANY NECESSARY MEDICAL TREATMENT OR ACTIONS BE PERFORMED TO ENSURE THE WELL BEING OF MY/OUR STUDENT ATHLETE.**

____ ________________________________

PARENT/LEGAL GUARDIAN SIGNATURE DATE

_____**YES** **I/WE DO** authorize the NorthWood Team Physician and/or Athletic Trainer to dispense non-prescription medication (Tylenol, Advil, etc.) to my/our student athlete if needed.

_____**NO** **I/WE DO NOT** authorize the NorthWood Team Physician and/or Athletic Trainer to dispense non-prescription medication (Tylenol, Advil, etc.) to my/our student athlete if needed.

CHOICE OF LOCAL HOSPITAL:____
ALLERGIES:____
MEDICATION:____

*****IN CASE I CAN"T BE REACHED, CALL:

____ ____________________________________

NAME PHONE #

____ ____________________________________

NAME PHONE #