School Year __2025-2026__ **ATHLETIC EMERGENCY CARD** Sport_____

_____
Student Name Age Date of Birth

_____
Student Address

_____
Doctor Preference Doctor's Phone No. Hospital Preference

Any special medical needs/drug allergies _____
Last Tetanus _____

1._____ Cell/Home Phone _____
Parent/Guardian Work/Alt Phone _____

2._____ Cell/Home Phone _____
Parent/Guardian Work/Alt Phone _____

3._____ Cell/Home Phone _____
Parent/Guardian Work/Alt Phone _____

Permission for Medical Services

I hereby give my consent for the student listed above while participating in a school-sponsored activity to receive medical services as necessary as determined by a doctor or other hospital staff member. (This is only to be used when the parent or legal guardian is not present and cannot be contacted.)

Parent/Legal Guardian Signature: _____

Student Name: _____ **Parent/Guardian Consent Form**

I, as parent or guardian of the student identified above, hereby grant permission to any athletic trainer or physician on site and providing sports related healthcare services at any, USD 437, Washburn Rural Middle School or Washburn Rural North Middle School sanctioned sports practice or competition to provide such treatment within the scope of professional services authorized for such athletic trainer or physician as deemed necessary for physical condition or treatment arising during or affecting participation in such event. I also grant permission to release medical information to the school, to the athletic trainer and to any subsequent physician or other provider as necessary for treatment of the student identified herein. This authorization to release medical information does not encompass release of any information to the media or to any university or school except that in which the above named student is enrolled. I acknowledge and agree that any such athletic trainer or physician may use his or her own judgment in securing medical aid, including ambulance and other emergency services as a result of any injury during participation in a school sanctioned event. I specifically consent and agree that the above referenced athletic trainer may provide preventative care and treatment of athletic injuries, evaluation of athletic injuries, first aid and emergency management of athletic injuries and rehabilitation and reconditioning of athletic injuries. By signing below, I agree and acknowledge that no athletic trainer or physician (nor the athletic trainer's or physician's employer, Stormont-Vail HealthCare, Inc.) assumes responsibility and is not liable for any accident or injury that may occur during the student's participation in an athletic event. I understand that the athletic trainer or physician (nor Stormont-Vail HealthCare, Inc.) is not involved in the school athletic program other than providing the services noted herein.

Parent/Guardian Name (PRINT): _____

Parent/Guardian Signature: _____ Date: _____