ILLINOIS SOUTHWEST ORTHOPEDICS SPORTS MEDICINE INJURY CLINIC

Consent to Treat and Emergency Contact Information

STUDENT NAME:_____ **DATE OF BIRTH:**_____

ADDRESS:_____ **CITY:**_____**ZIP:**_____

PARENT/GUARDIAN(S) NAME: _____

PARENT/GUARDIAN(S) CELL PHONE: _____

IN CASE OF AN EMERGENCY WHEN PARENT/GUARDIAN(S) CAN NOT BE REACHED PLEASE CONTACT:

NAME:_____ **RELATIONSHIP:**_____ **PHONE:**_____

NAME:_____ **RELATIONSHIP:**_____ **PHONE:**_____

Important Medical Information (Please elaborate yes answers)

Allergies Y / N _____

Asthma Y / N _____

Diabetes Y / N _____

Epilepsy Y / N _____

Heart Condition Y / N _____

Sickle Cell Anemia Y / N _____

Primary Care Physician _____**Phone:**_____

Health Insurance Information

Insurance Carrier and Type: _____

Member ID: _____**Group #:**_____

MEDICAL CONSENT

I authorize Gateway Regional Medical Center's medical providers and athletic trainers to provide me with any preventative, first-aid, rehabilitative, or emergency treatment deemed necessary to my health and well-being as a result of injuries or other medical conditions occurring as the result of or during athletic programs at or through Red Bud Community School District 132.

I give permission for my medical information to be released and discussed with the athletic training staff, organization nurses, team coaches, strength coaches, athletic administrators, faculty representatives, the student/participant insurance coordinator, medical clinics, hospitals, medical transporters, other health care providers attending to my care, parents and/or guardians.

If reasonably necessary to provide the care described in the preceding paragraphs, I grant permission to the Organization officials or Gateway Regional providers/athletic trainers to authorize my admission to a hospital or other facility that provides said treatment. I have read this Medical Consent in its entirety and understand and agree to its terms. **(_____Initials)**

I understand that I have the right to revoke all or any part of the above at any time by sending written notification to the Organization's athletic director. I understand that a revocation is not effective to the extent action has already been taken in reliance of this authorization/consent. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by federal privacy regulations. I understand I may see and copy the information described on this form if I ask for it, and that I may get a copy of this form after I sign it. I have read and fully understand the Organization athletic program requirements and all information supplied is accurate and is currently to the best of *my* knowledge.

Student Name (print): _____ **Student Signature:** _____ **Date:**_____

If student under 18 years of age:
Parent/guardian name (print): _____**Guardian Signature:**_____ **Date:**_____