Student-Athlete Health Information Disclosure Agreement

1.) STUDENT-ATHLETE

Student Name	Date of Birth
Address	City State Zip
School	Graduation Year

2.) AUTHORIZES

Aurora BayCare Sports Medicine Athletic Trainers
1160 Kepler Drive
Green Bay, WI 54311

3.) TO DISCLOSE HEALTH INFORMATION:

- To school officials, including athletic director, principal, coaching staff and physical education teachers regarding the health information of my son/daughter that affects his/her ability to participate in athletics.
- Update school officials on the health status of my son/daughter as it relates to ability to participate in athletics or returning him/her to play.

4.) CONSENT TO TREAT:

Assess and treat any injuries sustained by my son/daughter during participation of a school athletic event (practice of game) as indicated by their scope of practice.

Advise and seek emergency medical attention/transportation in the event that either parent or emergency contact person cannot be contacted by phone.

Provide the following over the counter medications to my son/daughter as necessary: antacid, Tylenol (acetaminophen), ibuprofen (Advil/Motrin), eye drops, allergy medications.

5.) EXPIRATION:

This authorization will expire four years from the date of signature, or upon graduation or departure from the school, whichever comes first.

My signature below certifies that I have read and understand this Health Disclosure Agreement.

6.) SIGNATURE OF STUDENT-ATHLETE'S LEGAL REPRESENTATIVE:

Parent/Guardian Signature	Date
Print Name	Relationship

Aurora BayCare
SPORTS MEDICINE

Aurora BayCare

SPORTS MEDICINE

Sports Medicine
Emergency Information and Consent

Student's Name:_____ Grade:_____
(Last) (First) (M.I.)
Student Address:_____ DOB:_____
Parent/Guardian Name:_____ Home Phone:_____
Day Phone Number: Father:_____ Mother:_____
Cell Phone Number: Father:_____ Mother:_____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name (& relation):_____ Phone(s):_____
Address:_____

MEDICAL INFORMATION

Family Doctor:_____ Phone:_____
Current Meds:_____ Known Allergies:_____
Other Conditions (asthma, diabetes, previous head injuries, surgeries, vision problems, etc.; use back of sheet if needed)

_____
_____
_____

MEDICAL CONSENT FOR TREATMENT

To Whom It May Concern:

The athletic staff (athletic trainers, coaches, or other school personnel) may apply first aid treatment for any injury or injuries sustained during participation (practice/game) in interschool athletics sanctioned by _____, until the parent/guardian can be contacted.

☐ **Yes** ☐ **No**

In case the parents can't be reached, we give consent for the athletic medical staff to use their own judgment in return to sport, securing medical aid, ambulance service, and if necessary hospital admittance, when needed, as a result of injury during participation in sanctioned practices/games scheduled by _____.

☐ **Yes** ☐ **No**

The athletic trainer may provide modalities such as but not limited to, ultrasound, electrical stimulation, ice and heat.

☐ **Yes** ☐ **No**

Parent Signature:_____ Date:_____

Student Signature:_____ Date:_____