

H.C.K.T. Athlete Permission and Emergency Medical Consent Form

Athlete's Full Name: _____ Birthdate: _____

Address: _____

Father's Name: _____ S.S.# _____

Mother's Name: _____ S.S.# _____

Parent's Phone: (H) _____ F/W: _____ M/W: _____

Other Emergency Contact: _____
name relationship

Phone Number: (H) _____ (W) _____

Family Physician: _____
name phone number

Medical Insurance: _____
carrier name policy number

Are you currently taking any medications? yes/no _____
please specify

Do you have any allergies? yes/no _____
please specify

Date of last tetanus shot: _____ Contacts/Glasses? yes/no _____

Any surgeries or serious injuries over the past 2 years? yes/no _____

Please specify: _____

Please include any other important medical information on the reverse side.

I the undersigned parent do hereby request that should the need arise, I authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any member of the medical staff and emergency room licensed under the provisions of the medicine Practice Act or a dentist licensed under the provisions of the Dental Practice Act and on the staff of any acute general hospital holding a current licence to operate a hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required; but is given to provide authority and power to render care which the aforementioned physician in the exercise of his best judgement may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatments will not be withheld if the undersigned cannot be reached, I will not hold the H.C.K.T or U.S.C.K.T. liable for medical aid rendered and will reimburse for medical or other expenses incurred in the care of my son/daughter.

Parent Signature: _____ Date: _____