

# ROCKY MOUNTAIN NORDIC

## ATHLETIC MEDICAL CONSENT FORM

**LEGAL NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_

(Please Print Last Name, First Name, Middle Name)

Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, X-ray examinations and immunizations for the above named individual. In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, the treatment necessary for the best interest of the above named individual may be given.

In the event that an medical emergency arises during a practice session or athletic meet or training camp, an effort will be made to contact the parents or guardians as soon as possible. Permission is also granted to the coaches to provide the needed emergency treatment to athlete prior to his admission to the medical facility.

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Please Print Name of Parent/Guardian** \_\_\_\_\_

**Phone Numbers where parents/guardians can be reached:**

**Home** \_\_\_\_\_ **Work** \_\_\_\_\_ **Cell** \_\_\_\_\_

**Home** \_\_\_\_\_ **Work** \_\_\_\_\_ **Cell** \_\_\_\_\_

**Family Physician** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Family Physician after office hours telephone #** \_\_\_\_\_

**Allergic to any Drugs or Medicines? Yes** \_\_\_\_\_ **No** \_\_\_\_\_

**If Yes, What?** \_\_\_\_\_

**Health problems that we should be aware of (Asthma, Diabetes, Etc):**

\_\_\_\_\_  
\_\_\_\_\_

**Health Insurance Company** \_\_\_\_\_

**Group Insurance Number** \_\_\_\_\_

**Individual Insurance Number** \_\_\_\_\_

**I hereby give permission to take pictures or give information to the News Media about my son or daughter for recognition: Yes** \_\_\_\_\_ **No** \_\_\_\_\_