Baugo Community Schools Consent to Treat

(This completed form is required for participation in any extracurricular program)

I _____ the legal representative/guardian of, _____,

born _____/_____/_____, do hereby consent to any medical care/treatment determined by the sports medicine staff to be necessary for the welfare of the participant in the event of an injury while participating in activities at Baugo Community Schools. I understand that any medical treatment or surgical care that is provided to the athlete will be given only when medically necessary for their health and wellbeing. I understand that the Beacon Health System, Inc. providers who provide care may be accompanied by students participating in Beacon Health System, Inc. sponsored education and outreach programs, and I consent to the presence of those students during care. I further consent to the participation of those students, under the direction of Beacon Health System, Inc. providers, in providing care and to the sharing of information about the participant and care with such students. By signing this form I acknowledge that I have read and understand this consent.
This authorization is affective from April 1, _____ to July 1, _____.

_____ _____/_____/_____

Signature of Legal Representative/Guardian Date

EMERGENCY INFORMATION (To be used by extracurricular program staff)

Student Name _____ Date of Birth _____ Gender ____ Grade ____

Address _____

Legal Representative: _____ Phone _____ email _____

Legal Representative: _____ Phone _____ email _____

FAMILY PHYSICIAN _____ Phone _____

Hospital Preference _____

PLEASE LIST ANY ALLERGIES (INCLUDE MEDICATIONS) AS WELL AS MEDICATIONS/CHRONIC CONDITIONS

_____

_____

EMERGENCY CONTACT IN CASE PARENT CANNOT BE REACHED

NAME _____ Relationship _____ Phone _____

Permission to administer over the counter medication

The Jimtown High School Licensed Athletic Trainer is hereby given permission to administer non-prescription, OTC medication to the above named student. Further consent is hereby given to administer prescription medication to the above named student when the prescription is properly labeled and in its original container.

I do ____ I do not ____ give permission for an OTC drug to be given to the above named student. **Please indicate any medications you do NOT want given to the above named student.** _____

Signature Of Legal Representative/Guardian _____ Date _____