

**2010 CONSENT FOR ATHLETIC TRAINING SERVICES AND
EMERGENCY MEDICAL TREATMENT**

(Must be completed and signed by the athlete's parent or guardian)

RETURN TO THE MUKWONAGO BRAVES

Student's name: _____ Date of Birth: _____

Student's address: _____ City: _____

Parent (Guardian) Name: _____

Home Phone: _____

Father: Work Phone: _____ Cell: _____

Mother: Work Phone: _____ Cell: _____

In case of emergency and the absence of parent/guardian, please list two people you recommend we call:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

List any known allergies: _____

List any medications being taken: _____

List any physical disabilities: _____

Additional comments: _____

CONSENT AND AUTHORIZATION

I hereby authorize the employed, contracted or volunteer staff of the participating teams to consent to any; athletic training services or necessary medical assistance on behalf of my son/daughter/ward. I further authorize these individuals to discuss my Son/daughter/ward's medical condition with other health care personnel. To the fullest extent permitted by law, I do hereby indemnify and hold harmless the Mukwonago Braves (contracting agency), entities and other persons who act in reliance upon this authorization.

Parent/Guardian Signature: _____ Date: _____