

# CONSENT TO TREAT & ATHLETIC PARTICIPATION / PERMISSION FORM

School: HCHS

School Year: 2022-2023

GRADE: \_\_\_\_\_

*This form is to be filled-out completely before a student can participate in any school athletic programs.*

STUDENT'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ Male / Female

ADDRESS OF STUDENT: \_\_\_\_\_; \_\_\_\_\_, NC

PARENT/GUARDIAN NAME(S): \_\_\_\_\_

Parent/Guardian Primary Phone: (#1) \_\_\_\_\_ H/W/C Relationship: \_\_\_\_\_

Parent/Guardian Secondary Phone: (#1) \_\_\_\_\_ H/W/C Relationship: \_\_\_\_\_

Parent/Guardian Primary Phone (#2) \_\_\_\_\_ H/W/C Relationship: \_\_\_\_\_

Parent/Guardian Secondary Phone (#2) \_\_\_\_\_ H/W/C Relationship: \_\_\_\_\_

Other Emergency Contact: \_\_\_\_\_ H/W/C Relationship: \_\_\_\_\_

I am interested in participating in the following sports:

## MEDICAL HISTORY - (To Be Completed By Parent/Legal Guardian)

### Is there any known history of:

If "Yes" - Explain:

A. Birth deformities (one eye, one kidney, etc.).	Yes___ No___	_____
B. Past illness of more than one week's duration?	Yes___ No___	_____
C. Medical conditions currently under treatment?	Yes___ No___	_____
D. Fractures or other disabling injuries?	Yes___ No___	_____
E. Any permanent deformity or disability?	Yes___ No___	_____
F. Allergy (drugs, food, clothing, etc.)?	Yes___ No___	_____
G. Mental disorder or convulsions?	Yes___ No___	_____
H. Current Medications?	Yes___ No___	_____

If you need more room to explain any above questions answered "Yes":

### In the event your child should need emergency care, please provide the information below:

If you do not have insurance, your child will be covered under the Harnett County Board of Education Policy and will act as primary insurance. However, this policy is limited and may not cover all expenses or pay for every accident. If you do have insurance coverage for your child, the school's policy will act as secondary insurance.

Health Insurance Company Name: \_\_\_\_\_

Insurance Policy # \_\_\_\_\_

Physician's Name & Office Phone #: \_\_\_\_\_

Does your insurance company require a referral from your primary care physician? \_\_\_\_\_ Yes \_\_\_\_\_ No

## PARENT PERMISSION

As the parent/legal guardian, I give consent for the above named student-athlete to receive a medical screening prior to participation in athletics. If the student-athlete is injured while participating in athletics and the school is unable to contact the parent/legal guardian, I grant permission for treatment deemed necessary for a condition arising during participation in these activities. Treatment may include, but is not limited to, first aid, CPR, use of AED, or medical/surgical intervention as recommended by a physician. As parent/guardian, I accept the financial responsibility for any such medical care and treatment.

Either a Licensed Athletic Trainer or a trained first responder is available for high school student athletes. Licensed Athletic Trainers within their scope of practice and protocol, provide treatment, care, prevention and rehabilitation of injuries incurred by student athletes during school sponsored athletic activities. Injury treatment may include the application of modalities including but not limited to heat, cold, sound, light, electricity, and mechanical devices related to rehabilitation and therapeutic exercises to safely enhance recovery time and return to activity. First responders may use the application of heat and ice and render first aid within their scope of practice. I give my permission for the release and exchange of health related information with my child's physician and the athletic team members necessary to appropriately care for my child. I hereby state that the above information is correct and I will hereby notify the school if any changes occur.

Signature of Parent or Legal Guardian

Date