Aurora Medical Center Two Rivers, Wisconsin Manitowoc County

Sports Medicine
Emergency Information and Consent

Student's Name:_____ Grade:_____
(Last) (First) (M.I.)
Sports:_____
Student Address:_____ DOB:_____
Parent/Guardian Name:_____ Home Phone:_____
Day Phone Number: Parent/Guardian 1:_____ Parent/Guardian 2:_____
Cell Phone Number: Parent/Guardian 1:_____ Parent/Guardian 2:_____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name (& relation):_____ Phone(s):_____
Address:_____

MEDICAL INFORMATION

Family Doctor:_____ Phone:_____
Current Meds:_____ Known Allergies:_____
Other Conditions (asthma, diabetes, previous head injuries, surgeries, vision problems, etc.; use back of sheet if needed)

_____
_____
_____

MEDICAL CONSENT FOR TREATMENT

To Whom It May Concern:

The athletic staff (athletic trainers, coaches, or other school personnel) may apply first aid treatment for any injury or injuries sustained during participation (practice/game) in interschool athletics sanctioned by **Manitowoc Public School District**, until the parent/guardian can be contacted.
☐ **Yes** ☐ **No**

In case the parents/guardians can't be reached, we give consent for the athletic medical staff to use their own judgment in return to sport, securing medical aid, ambulance service, and if necessary hospital admittance, when needed, as a result of injury during participation in sanctioned practices/games scheduled by **Manitowoc Public School District**.
☐ **Yes** ☐ **No**

The athletic trainer may provide modalities such as but not limited to, ultrasound, electrical stimulation, ice and heat.
☐ **Yes** ☐ **No**

Parent Signature:_____ Date:_____

Student Signature:_____ Date:_____

Manitowoc Public School District

Medication Consent Form

Student Name_____ D.O.B._____ School_____ Grade____Phone_____

Prescribing Provider_____ Prescriber Phone_____Prescriber Fax_____

Parent: I request that my child receive the medication or procedure at the time indicated and as designated by his/her medical provider. I will be responsible for bringing the medication to school in a labeled original container, and for maintaining a sufficient quantity of the medication or supplies at school. School personnel have permission to communicate with the prescribing medical provider regarding use, side effects, response and contraindications of the medication or procedure results or frequency. I can revoke my permission at any time. I agree to inform the school of any changes in the medication or if the medication is stopped. I further agree to hold the MPSD and all employees harmless in any and all claims arising from the administration of the medication at school.

Parent Consent for Prescriptions/Over the Counter Medications

Medication	Route	Dose/Frequency	Time	Reason for Medication

**Parents are REQUIRED to pick up all medication at school when discontinued or at the end of the school year. Medications left after the last day of school will be properly disposed of by the School Nurse.

_____ _____ _____

Printed name of Parent/Guardian Signature of Parent/Guardian Date

---

Prescription Medications (to be completed and signed by Health Care Provider)

Medication/Diagnosis	Route	Dose/Frequency	Time	Self-Carry	Possible Side Effects

Procedures

Name of Procedure	Dose/Frequency	Time	Start date	Stop date	Monitoring Parameters

The above orders shall be effective throughout the current school year, unless the orders are discontinued, changed or withdrawn in writing by the parent/guardian before this time elapses. Students 6th grade and above may self carry emergency medications with health care provider consent.

Physician: (Prescription Drugs Only)

_____ _____ _____

Signature of Physician Printed Name of Physician Date