

**CALIFORNIA DEPARTMENT OF EDUCATION**  
**California School for the Deaf-Fremont**  
**SPORTS MEDICAL CONSENT FOR TREATMENT FORM**

**ATHLETE NAME:** \_\_\_\_\_ **Year 2010-2011**

- 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 ATHLETE. IN THE EVENT OF SERIOUS ILLNESS, OR THE NEED FOR SURGERY, OR THE 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 THE ATTENDING PHYSICIAN IS NOT ABLE TO COMMUNICATE WITH ME, THE TREATMENT NECESSARY IN THE BEST INTEREST OF THE ABOVE NAMED ATHLETE MAY BE GIVEN.
- IN THE EVENT THAT AN EMERGENCY ARISES DURING PRACTICE OR A GAME, AN EFFORT WILL BE MADE TO CONTACT THE PARENTS OR GUARDIANS AS SOON AS POSSIBLE.
- PERMISSION IS ALSO GRANTED TO THE ATHLETIC TRAINERS TO PROVIDE THE NEEDED EMERGENCY TREATMENT, REGULAR INJURY TREATMENT AS NECESSARY IN THE BEST INTEREST OF THE ABOVE NAMED ATHLETE.
- PERMISSION IS ALSO GRANTED TO THE ATHLETIC TRAINERS TO PROVIDE OVER THE COUNTER MEDICATION IN CASE OF MINOR ILLNESS, WITH OUR TEAM PHYSICIAN CONSENT. EXAMPLES: TYLENOL/ADVIL.

\_\_\_\_\_  
**SIGNATURE OF PARENT OR GUARDIAN**

\_\_\_\_\_  
**DATE**

**RELEASE OF MEDICAL RECORDS AND MEDICAL INFORMATION:**

**I AUTHORIZE THE RELEASE OF ANY AND ALL MEDICAL RECORDS AND INFORMATION TO THE ATHLETIC TRAINERS AND STUDENT HEALTH STAFF OF THE CALIFORNIA SCHOOL FOR THE DEAF-FREMONT. I ALSO AUTHORIZE THE STUDENT HEALTH STAFF TO RELEASE MY MEDICAL INFORMATION TO THE COACHING STAFF AND APPROPRIATE CSD STAFF.**

(\_\_\_\_\_) \_\_\_\_\_  
 Home Phone

(\_\_\_\_\_) \_\_\_\_\_  
 Cell Phone

(\_\_\_\_\_) \_\_\_\_\_  
 Work Phone

VP Phone \_\_\_\_\_

\_\_\_\_\_ Email/Pager

Address with Person's Name & Relationship

(\_\_\_\_\_) \_\_\_\_\_  
 Emergency Phone or VP# with Person's Name & Relationship

<b>Insurance</b>	<b>Policy, Group or Card Number</b>	<b>Issue Date</b>

Please list all **ALLERGIES** your child has. Tell us what the reactions are if known. If no allergies, please state NONE. \_\_\_\_\_

**PARENT/GUARDIAN/ADULT STUDENT** \_\_\_\_\_ **DATE** \_\_\_\_\_

**\*\*INSURANCE INFORMATION IS REQUIRED BEFORE PARTICIPATION IN SPORTS.\*\***