STATEMENT OF UNDERSTANDING & MEDICAL CONSENT FORM

(This form will be kept on file in the athletic office; any changes please change in athletic office.)

We, the parents of _____ (print name of student) do hereby acknowledge that we have been advised, cautioned, and warned by the proper administrative and coaching personnel of Randolph Southern School Corporation that our child may suffer serious injury, including but not limited to sprains, fractures, brain damage, paralysis or even death by participation in sports. Notwithstanding such warnings and with full knowledge and understanding of the risk of serious injury, the above named student has our consent to participate in interscholastic sports. We realize that we are responsible for medical and/or transportation expenses that may result from injuries incurred during his/her participation in the athletic program. _____ (Initial).

In the event that an emergency occurs during a practice session or a game an effort will be made to contact the parents or guardians as soon as possible. If the parents or guardians cannot be reached permission is hereby granted to the attending physician to proceed with any emergency medical or minor surgical treatments, x-ray examinations and immunizations for this athlete _____ (initial). In the event of serious illness, significant injury, or the need for major surgery, the attending physician will attempt to contact parents or relatives. If the physician is not able to communicate with the parents or relatives, the treatment necessary for the best interest of this athlete may be given. Permission is also granted to the coach or athletic trainer to provide the needed emergency treatment to the athlete prior to admission to the medical facilities.

_____

Parent/Guardian Signature Date Hospital Preference

_____

Parent/Guardian Signature Date Medical Insurance Company

_____

Student Signature Date

MEDICAL INFORMATION

Student's Name_____ Birth date _____

Address _____ Home Phone _____

Parents/Guardians Names

Father_____ Work Phone _____

Mother_____ Work Phone _____

Name of relative, close friend or neighbor to be contacted if parents cannot be located.

_____ Relationship _____ Phone _____

Family Physician _____ Office Phone_____

Family Dentist _____ Office Phone_____

Family Optometrist _____ Office Phone_____

Circle if you wear GLASSES HARD CONTACTS SOFT CONTACTS

Please list/describe on the back of this form any allergies, health problems (such as asthma or diabetes), injuries you have had or medications you take regularly.