ATHLETIC FORMS

All forms **MUST** be filled out and returned to your coach prior to participation.

EMERGENCY MEDICAL AUTHORIZATION
PART I -OR- PART II MUST BE COMPLETED

Student Name______________________ School ______________________
Address______________________ Teacher______________________
______________________ Grade________ Date of Birth____________

Mother's Name______________________ Father's Name______________________
Phone #______________________ Phone #______________________

Student resides with ___Mother ___Father ___Both ___Guardian ___Other:______________________

PART I – TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor______________________ Phone______________________
Dentist______________________ Phone______________________
Medical Specialist______________________ Phone______________________
Local Hospital______________________ Emergency Room Phone______________________

Medical information about my child:

___Allergies (is so, explain)______________________ Does child require an Epi Pen?________
___Asthma ____Diabetes ____Seizures ____Hearing Difficulty ____Kidney Problems _____Wears Glasses
___Heart Related (high blood pressure, heart murmur....) ____Other (explain)______________________
____

Current Medications the student is taking:______________________
____

Will student be taking any medication at school?________ *If yes, please ask nurse/office for medication form.*

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Signature of Parent/Guardian______________________ Date______________

EMERGENCY CONTACTS (please list in order to be contacted):

NAME	RELATIONSHIP	HOME PHONE	CELL PHONE

PART II – REFUSAL TO CONSENT

I do **NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

____

Signature of Parent/Guardian______________________ Date______________

INSURANCE INFORMATION FORM

Section 1:

ATHLETE COMPLETE

Athlete Name:______________ Social Security #:______________ Date of Birth:______________ Sport:______________

Home Address:______________ (Street, City, State, Zip) Home Phone:______________ Cell Phone:______________

PARENT/GUARDIAN

Father's Name:______________ Date of Birth:______________

Email Address:______________

Address:______________ (Street, City, State, ZIP)

Phone:______________ Social Security #:______________

Employer:______________ Occupation:______________

Employer's Address:______________ (Street, City, State, ZIP)

Work Phone:______________ EXT:______________

Mother's Name:______________ Date of Birth:______________

Email Address:______________

Address:______________ (Street, City, State, ZIP)

Phone:______________ Social Security #:______________

Employer:______________ Occupation:______________

Employer's Address:______________ (Street, City, State, ZIP)

Work Phone:______________ EXT:______________

TO BE COMPLETED BY PARENT/GUARDIAN

Is this athlete covered at this time by your present surgical and hospital insurance policy? YES____ NO____

If yes, complete the following (list THE PHONE NUMBER(S), address, and all appropriate insurance policy numbers).

FATHER/GUARDIAN (Please duplicate front & back of insurance card and attach)

Medical Insurance Company:______________

Phone:______________

Address:______________ (Street, City, State, ZIP)

Policy #:______________ Certificate #:______________

Group #:______________ Additional #:______________

Primary Care Physician:______________ PCP Phone:______________

Does this insurance plan require a second opinion for surgery? YES/NO

MOTHER/GUARDIAN (Please duplicate front & back of insurance card and attach)

Medical Insurance Company:______________

Phone:______________

Address:______________ (Street, City, State, ZIP)

Policy #:______________ Certificate #:______________

Group #:______________ Additional #:______________

Primary Care Physician:______________ PCP Phone:______________

Does this insurance plan require a second opinion for surgery? YES/NO

______________ Athlete's Signature ______________ DATE

______________ Parent/Guardian Signature (Policyholder) ______________ DATE

CONSENT FOR COGNITIVE TESTING and RELEASE OF INFORMATION

I give my permission for (name of child) ______________________________

(child's date of birth) __________________________

to have a post-concussion ImPACT® (Immediate Post-concussion Assessment and Cognitive Testing) administered at Meigs JR/Sr High SchoolI understand that my child may need to be tested more than once, depending upon the results of the test, as compared to my child's baseline test, which is on file at Meigs Jr/Sr High School

Meigs Jr/Sr High School may release the ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) results to my child's primary care physician, neurologist, or other treating physician, as indicated below.

I understand that general information about the test data may be provided to my child's guidance counselor and teachers, for the purposes of providing temporary academic modifications, if necessary.

Print Name of parent or guardian: ______________________________________

Signature of parent or guardian: ______________________________________

Date: ________________________________

PLEASE PRINT THE FOLLOWING INFORMATION:

Name of doctor: ________________________________

Name of practice or group: ________________________________

Phone number: ________________________________

Student's home address: ____

Parent or guardian phone numbers (please indicate preferred contact number & time if necessary):

______________________ (H) __________________________ (W)

______________________ (cell)

2/2013

MEIGS LOCAL SCHOOL DISTRICT

POMEROY, OHIO

PARENT/GUARDIAN CONSENT TO PERFORM URINALYSIS

FOR DRUG/ALCOHOL TESTING

I hereby consent to have my son/daughter undergo urinalysis testing for the presence of drugs or alcohol in accordance with the Meigs Local Drug and Alcohol Testing Policy for Student Athletes.

I understand that this testing will occur according to the guidelines of the Meigs Local Drug and Alcohol Testing Policy for Student Athletes.

I understand that any urine samples taken for drug/alcohol testing will be sent only to a certified medical laboratory for actual testing.

I hereby give my consent to the medical laboratory selected by the Meigs Local Board of Education, its doctors, employees, or agents, together with any clinic, hospital, or laboratory designated by the selected medical laboratory, to perform urinalysis testing on my son/daughter for the detection of drugs/alcohol.

I further give my permission to the medical laboratory selected by the Meigs Local Board of Education, its doctors, employees, or agents to release all results of these tests to designated School District employees or agents. I understand that these results will also be made available to me.

This form must be accompanied by a Student Consent Form.

I hereby release, waive, and discharge the Meigs Local Board of Education its individual members, employees, agents, and anyone acting on its behalf from any and all liability claims, or causes of action arising from or related to the urinalysis drug/alcohol testing for student athletes and/or the release of related information as authorized in this form and in the Drug and Alcohol Testing Policy for Student Athletes.

______________________________ ______________________________

Student/Athlete Signature Parent/Legal Guardian Signature

______________________________ ______________________________

Date Date