# Hobart High School
# Athletic Department
# 942-8521

**RETURN THIS FORM TO THE ATHLETIC DEPARTMENT**

STATEMENT OF CONSENT TO ADMINISTER EMERGENCY TREATMENT
AND ASSUMPTION OF ALL LIABILITY FOR EMERGENCY MEDICAL TREATMENT

I/We, the parent(s) legal guardian(s) of **(Name in full of Student)**_____ **(Grade)**_____ do herein and hereby grant my/our permission to Principal, Athletic Director and the Athletic Trainer of Hobart High School or, to any qualified medical personnel in attendance, to administer or authorize to be administered, emergency medical treatment should the above named individual be injured while participating in any supervised practice session or while participating in any game, meet and/or competition which is sanctioned by and is a part of the scheduled program of athletics administered by the Department of Athletics, Hobart High School.

I/We further understand that EMERGENCY shall mean any injury which results in excessive bleeding; loss of psychomotor function in the body or any portion thereof; fracture (whether suspected or evident) or protrusion of any bone of the leg, hip, chest, shoulder, arm or neck and head; injury to the eye caused by gouging, poking, cutting, or use of chemicals; and/or which, in the opinion of the Principal, Athletic Director, Trainer, Coaching Staff, Doctor, or other qualified medical personnel present, constitutes an injury which requires immediate preventative, curative, or reparative treatment.

I/We do further understand and agree that as the parent(s) legal guardian(s) of the above named individual, that all costs arising out of and resulting from said emergency treatment, including transporting of the individual by ambulance, shall be borne by me/us and the Principal, Athletic Director, Trainer and/or Coaching Staff of Hobart High School are hereby released from any emergency medical treatment. I further understand that the Department of Athletics, Hobart High School, and the School City of Hobart do not carry any type of medical liability or health insurance from which reimbursement, either in part or in whole, may be obtained from said medical expenses.

**STUDENT'S LAST NAME:**_____ **FIRST:**_____ **MI:**_____

**GENDER:**_____ **GRAD YEAR:**_____ **BIRTHDATE:**_____ **EMAIL:** _____

**ADDRESS:**_____ **CITY:**_____ **STATE:**____ **ZIP:**_____

**MOTHER'S LAST NAME:**_____ **FIRST:**_____

**FATHER'S LAST NAME:**_____ **FIRST:**_____

**HOME PHONE:**_____ **CELL PHONE:**_____ **WORK PHONE:**_____

**LIVES WITH:**_____

**FAMILY DOCTOR:**_____ **ADDRESS:**_____ **PHONE:**_____

**INSURANCE COMPANY NAME:**_____ **POLICY NUMBER:**_____

**EMERGENCY CONTACT:**_____ **EMERGENCY CONTACT**:_____

**MY CHILD IS COVERED BY MY FAMILY INSURANCE: _____ YES _____ NO**

**The athletic department is seeking your permission to have your son/daughter treated at a doctor's office or hospital emergency room in the event that he/she is found in need of emergency medical treatment. If an emergency occurs every effort will be made to contact you. If such contact is not possible this card may facilitate prompt medical treatment.**

**I HEREBY GIVE MY PERMISSION FOR _____ TO RECEIVE EMERGENCY MEDICAL TREATMENT.**
**ATHLETE NAME**

_____ _____ _____
**PARENT OR GUARDIAN SIGNATURE** **DATE** **SPORTS PARTICIPATING IN**