

**WILEY SCHOOL DISTRICT RE-13JT  
Athletic Emergency/Consent Form**

Name of Student \_\_\_\_\_ Parent \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_ Work # \_\_\_\_\_

EMERGENCY CONTACT NAME AND PHONE # \_\_\_\_\_

INSURANCE CO. \_\_\_\_\_ POLICY # \_\_\_\_\_

FAMILY DOCTOR \_\_\_\_\_ PHONE \_\_\_\_\_

I, \_\_\_\_\_, (Parent/Guardian) of \_\_\_\_\_, in consideration of my child's opportunity to participate in interscholastic activities, hereby consent to emergency medical treatment as may be necessary for the welfare of the above named child, by a physician, qualified nurse, and or hospital. In the event of an injury or illness during all periods of time in which the student is away from his/her legal residence as a member of an interscholastic activity team or group, and hereby waive on behalf of myself and the above named child any liability of the Wiley School District, any of its agents or employees, arising out of such medical treatment. I also verify that \_\_\_\_\_ (STUDENT) is covered by a hospitalization insurance program. We will NOT hold Wiley School responsible for any doctor or hospital bill that might result from any injury he/she might receive.

Signed \_\_\_\_\_ (Parent/Guardian) Date \_\_\_\_\_

Signed \_\_\_\_\_ (Student) Date \_\_\_\_\_

**NOTICE TO ATHLETES**

By its very nature, competitive athletics may put students in situations in which **SERIOUS CATASTROPHIC and perhaps FATAL ACCIDENTS** may occur. Many forms of athletic competition result in violent, physical contact among players, the use of equipment which may result in accidents, strenuous physical exertion and numerous other exposures to risk of injury. Students and parents must assess the risks involved in such participation and make their choice to participate despite those risks. No amount of instruction, precaution, or supervision will totally eliminate all risk of injury. The obligation of parents and students in making this choice to participate cannot be over stated. By granting permission for your child to participate in athletics, you the parent or guardian, acknowledge that such risk exists. By choosing to participate you and the student acknowledge that such risk exists.

Students will be instructed in proper techniques to be used in athletic competition and in the proper utilization of all equipment worn or used in practice and competition. Students MUST adhere to that instruction and utilization and MUST refrain from improper uses and techniques. Players must obey all safety rules and report all physical problems to their coaches. As previously stated, no amount of instruction, precaution, and supervision will totally eliminate all risk of serious, catastrophic or even fatal injury. If any of the foregoing is not completely understood, please contact your school principal for further information.

I HEREBY GIVE MY CONSENT FOR \_\_\_\_\_ (STUDENT) TO COMPETE IN ATHLETICS FOR WILEY SCHOOL DISTRICT RE-13JT, IN THE FOLLOWING CHSAA APPROVED SPORTS:

(PLEASE CIRCLE) FB SB VB W BSB BB TR CL

THIS STATEMENT ACKNOWLEDGES THAT WE HAVE READ AND UNDERSTAND THE MATERIAL DESCRIBED ABOVE.

Parent/Guardian \_\_\_\_\_ Student \_\_\_\_\_ Date \_\_\_\_\_

TO BE COMPLETED BY STUDENT AND/OR PARENT

Date \_\_\_\_\_ Physician \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

1. Have you ever been hospitalized?  
Have you ever had surgery? Yes \_\_\_ No \_\_\_
2. Are you presently taking any medications or pills? Yes \_\_\_ No \_\_\_
3. Do you have any allergies (medicine, bees or other stinging insects)? Yes \_\_\_ No \_\_\_
4. Have you ever passed out during or after exercise? Yes \_\_\_ No \_\_\_
- Have you ever been dizzy during or after exercise? Yes \_\_\_ No \_\_\_
- Have you ever had chest pain during or after exercise? Yes \_\_\_ No \_\_\_
- Do you tire more quickly than your friends during exercise? Yes \_\_\_ No \_\_\_
- Have you ever had high blood pressure? Yes \_\_\_ No \_\_\_
- Have you ever been told that you have a heart murmur? Yes \_\_\_ No \_\_\_
- Have you ever had racing of your heart or skipped heartbeats? Yes \_\_\_ No \_\_\_
- Has anyone in your family died of heart problems or a sudden death before age 50? Yes \_\_\_ No \_\_\_
5. Do you have any skin problems (itching, rashes, acne)? Yes \_\_\_ No \_\_\_
6. Have you ever had a head injury? Yes \_\_\_ No \_\_\_
- Have you ever been knocked out or unconscious? Yes \_\_\_ No \_\_\_
- Have you ever had a seizure? Yes \_\_\_ No \_\_\_
- Have you ever had a stinger, burner or pinched nerve? Yes \_\_\_ No \_\_\_
7. Have you ever had heat or muscle cramps? Yes \_\_\_ No \_\_\_
- Have you ever been dizzy or passed out in the heat? Yes \_\_\_ No \_\_\_
8. Do you have trouble breathing or do you cough during or after activity? Yes \_\_\_ No \_\_\_
9. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guard, etc.)? Yes \_\_\_ No \_\_\_
10. Have you had any problems with your eyes or vision? Yes \_\_\_ No \_\_\_
- Do you wear glasses or contacts or protective eyewear? Yes \_\_\_ No \_\_\_
11. Have you ever sprained/strained, dislocated, fractured, broken or had repeated or other injuries of any bones or joints? Yes \_\_\_ No \_\_\_
- \_\_\_ Head \_\_\_ Shoulder \_\_\_ Thigh \_\_\_ Neck \_\_\_ Elbow \_\_\_ Knee
- \_\_\_ Foot \_\_\_ Forearm \_\_\_ Shin/Calf \_\_\_ Back \_\_\_ Wrist \_\_\_ Ankle
- \_\_\_ Chest \_\_\_ Hip \_\_\_ Hand
12. Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)? Yes \_\_\_ No \_\_\_
13. Have you had a medical problem or injury since your last evaluation? Yes \_\_\_ No \_\_\_
14. When was your last tetanus shot? \_\_\_\_\_
- When was your last measles immunization? \_\_\_\_\_
15. When was your first menstrual period? \_\_\_\_\_
- When was your last menstrual period? \_\_\_\_\_
- What was the longest time between your periods last year? \_\_\_\_\_

Explain "yes" answers:

TO BE COMPLETED BY PHYSICIAN

Height _____	Weight _____	BP _____	/	Pulse _____
Vision R 20/ _____	Vision L 20/ _____	Corrected: Y N	Pupils _____	
Normal		Abnormal Findings		
Cardiopulmonary				
Pulses				
Heart				
Lungs				
Tanner Stage		1	2	3 4 5
Skin				
Abdomen				
Genitalia				
Musculoskeletal				
Neck				
Shoulder				
Elbow				
Wrist				
Hand				
Back				
Knee				
Ankle				
Foot				
Other				

CLEARANCE

- A. Cleared \_\_\_\_\_
- B. Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_
- C. Not Cleared for: \_\_\_\_\_
- \_\_\_ Collision \_\_\_ Contact
- \_\_\_ Non-contact ( \_\_\_ Strenuous \_\_\_ Moderately Strenuous \_\_\_ Non-Strenuous)
- Recommendation: \_\_\_\_\_

Signature of Athlete

Date

Signature of parent/guardian

Date

Name of Physician/PA or Nurse Practitioner

Address

Phone

Signature of MD/PA/NP Exp. Date (365 Days)

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.