

# DURANGO HIGH MEDICAL CONSENT FORM

STUDENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

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 student. In the event of serious illness, the need for major surgery, or 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 said physician is not able to communicate with me, the treatment necessary for the best interest of the above named student may be given.

In the event that an emergency arises during a practice session, an effort will be made to contact the parent(s) or guardian as soon as possible. Permission is also granted to the athletic trainer to provide the needed emergency treatment to the athlete prior to his admission to the medical facilities.

\_\_\_\_\_  
Parent(s) or Guardian Date

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Email Address \_\_\_\_\_

Phone number where parent(s)/guardian may be reached:

Office: \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Allergic to any drugs or medicines? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, What? \_\_\_\_\_

Do you wear contacts? Yes \_\_\_\_\_ No \_\_\_\_\_

Health problems that we should be aware of (asthma, diabetes, etc.): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Birthday of Student: \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_

\_\_\_\_\_  
Parent(s) or Guardian Signature