Centralia High School
Consent to Treat

Student Athlete: ______________________________

I (We) understand that St. Mary's Hospital, when requested from time to time, will provide a member of its staff to provide sports medicine services to the School District's athletes at athletic contests and practices. I authorize St. Mary's Hospital Sports Medicine Staff to assist with medical care, treatment, and training of my student athlete, when St. Mary's Hospital staff is available at the event.

In the event of an injury or accident to our child during his/her participation in an athletic activity, school district officials are authorized to seek immediate medical attention or assistance at the nearest medical facility, if the same is deemed appropriate.

This Consent will remain in full force and effect until revoked by the undersigned.

Father:______________________________ Date:_________

Mother:______________________________ Date:_________

Legal Gaurdian:_______________________ Date:_________

Student:_____________________________ Date:_________

PLEASE FILL OUT AND SIGN BOTH SIDES OF THIS SHEET

PARENTAL PERMISSION TO PARTICIPATE IN ATHLETICS

TO: Athletic Director
Centralia High School

This is to certify that our son/daughter ______________________________
Name of Athlete

has our permission to take part in interscholastic athletics at Centralia High School.

In case our son/daughter is injured we prefer treatment be by:

Check Only One

The Team Physician
or
Our Family Physician, who is ________________________

EMERGENCY INFORMATION

Name of Athlete ______________________________ Year in School __________
Grade

Mailing Address ______________________________ Telephone ______________

City ______________________________ Zip Code ______________

Date of Birth ______________________ Birth Place ______________
Mo - Day - Year County/State

Name of Father ______________________ Business Phone ______________

Name of Mother ______________________ Business Phone ______________

Name of responsible adult who will assume responsibility for the student if parents cannot be reached

______________________________ Phone ______________

Physician ______________________________ Phone ______________

Hospital of Choice ____

If you and the physician of your choice as indicated cannot be reached in any emergency and if in the judgment of the school authorities immediate medical and/or hospital attention is indicated do you authorize responsible school authorities to send your child (properly accompanied) to an available hospital or physician?

Yes ______ No ______

Date ____________________ ______________________________
Signature of parent or Guardian

OVER