CONSENT FOR TREATMENT

Athletics Department
PO Box 670, Ocala, FL 34478

Last Name _____ First Name _____

Birth Date _____ Sport _____

The Marion County School Board utilizes Athletic Trainers who are qualified to evaluate and assist in treating most injuries and illnesses that your child might sustain while participating in our athletic program. These Athletic Trainers are certified by the National Athletic Trainers Association Board of Certification, Inc. and licensed by the State of Florida. In the event a physician's consultation is required for your child, our policy is to refer to an authorized team physician. The School Board makes a reasonable effort to contact you before medical referral is made and to utilize the physician of your preference as indicated below. However, in the event of an emergency, the need for prompt action may preclude the School Board contacting you prior to medical treatment and may preclude the use of your preferred physician.

I give my permission for the Athletic Trainers authorized by Marion County School Board to evaluate and treat my child. In the event that a physician's evaluation or treatment is deemed necessary. [check one ☑]

- ☐ *I give permission to refer my child to the authorized team physician and consent to the team physician evaluating and treating my child as appropriate.* **-OR-**
- ☐ *I prefer that you refer my child to the physician designated below. Refer my child to the team physician only if referral to my designated physician is not possible.*

- *I also give my consent for my child's treating physician and for the team physician, athletic trainer or other designated medical personnel to release to each other and to School Board employees, such information regarding my child's medical history, record of injury or illness, and treatment/rehabilitation as may be deemed necessary to protect my child's health and well-being during his/her participation in athletics.*
- *I further give my permission for appropriate school staff or their designees to render emergency treatment or authorize medical treatment by a hospital and/or physician and agree to hold the School Board and its employees harmless in the administration of such medical assistance.*

Preferred Physician's Name _____

Office Address _____ Phone # _____

~IMPORTANT EMERGENCY INFORMATION AND PARENT/GUARDIAN SIGNATURE IS REQUIRED BELOW~

EMERGENCY CONTACT INFORMATION

1) Parent/Guardian _____ Home # _____ Work # _____ Cell # _____

2) Name _____ Home # _____ Work # _____ Cell # _____

3) Name _____ Home # _____ Work # _____ Cell # _____

ATHLETE'S BRIEF MEDICAL HISTORY:
List any condition the athlete has received medical attention for during the past two (2) years. Please include name of provider.

_____

_____

List any allergies (food, medication, insect stings, etc.)

_____

List any medications the athlete is regularly taking

_____

I understand that if a parent, guardian or student falsifies any signature(s) or any other information on this form, the student will be declared ineligible for one full calendar year from the disclosure date. I hereby state that I have read both sides of this form and the information given above is true and correct to the best of my knowledge and belief.

Parent/Guardian Signature _____ Date _____
(District requires a physical signature)

Student Signature _____ Date _____
(District requires a physical signature)

~ An Equal Opportunity School District ~