

Brick Memorial Mustangs Ice Hockey Emergency Card

Name: _____ Age: _____
Address: _____ Phone: _____

Father: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

Mother: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

If parent cannot be reached, who should the school contact to be responsible for this athlete

Name: _____ Phone: _____
Relationship: _____

Family Physician: _____ Phone: _____
Insurance Company: _____ Policy / Group #: _____

Known allergies to medication or other conditions the school should be aware of: _____

PERMISSION TO PROVIDE MEDICAL TREATMENT AGREEMENT

I HEREBY give my permission for my son/daughter, _____ to undergo medical treatment for any injury or illness he/she may sustain or acquire while engaged in inter-scholastic athletics at Brick Township School District, I understand that the medical personnel of Brick Township Schools, including athletic trainers, nurses, and team physicians will perform only those procedures which are within their training, credentialing and scope of professional practice to prevent, care for, and rehabilitate athletic injuries. In the event that more serious medical procedures are required, such as surgery or other invasive procedures, I understand that attempts will be made to contact me for my consent. I understand that if my child suffers a potentially life threatening injury or illness, and in the event I am unable to be contacted within a reasonable period of time, that I authorize any duly licensed medical practitioner to perform such procedures as may be medically necessary to alleviate the problem.

I have had the opportunity to ask questions regarding this release and all of my questions have been answered to my satisfaction. Having understood the above agreement, I freely sign this Permission to Provide Medical Treatment Agreement.

Date _____ Signature of Parent or Legal Guardian _____