USD 449 PLEASANT RIDGE SCHOOLS

EMERGENCY MEDICAL AND CONSENT FORM

This form will be made available by the coach at all team practices and athletic contests for each team member to ensure proper treatment by physicians or hospitals in the event of a serious injury.

Name of Student:________________________ Birth Date:______________ Grade:______________
Name of Parents:_____________________________________ Home Phone:_____________________ Day Phone: ________________
Address:____ City:_________________________ State:_____________________ Cell Phone of Parents: Father:_________________________ Mother:__________________________ In Case of an Emergency, if parents cannot be reached notify: Name:___________________________ Phone:_____________________ I hereby give consent for medical treatment deemed necessary by physicians/trainers designated by school authorities and/or for transportation by ambulance to the hospital emergency room for treatment for any serious illness or injury from his/her participation.

Preferred Physician:__________________________ Phone:_______________________________

Known Allergies or Conditions:____

MEDICAL INFORMATION RELEASE

I am aware that if my child sustains an injury and is participating in a school sponsored sport(s), it is imperative that the athletic trainer or physician be able to communicate with coaches, staff, medical personnel, administration and physicians. I hereby authorize and consent to the release of any pertinent medical information and records regarding the treatment, diagnosis, and/or examination relative to injuries or serious illness that may affect my participation in USD 449 Pleasant Ridge athletics. I understand that I can revoke this authorization at any time in writing to the USD 449 Pleasant Ridge Athletic Director. Unless I exercise this right to revoke this authorization this said release will be in effect during the duration of my participation in athletics for the USD 449 Pleasant Ridge 2025-26 school year.

I elect to **OPT OUT** of Medical Information Release____

I elect to **OPT IN** to the medical Information Release (Parent/ Guardian)

CONSENT TO TREAT

In the event that my child develops an illness or sustains an injury while participating on a USD 449 Pleasant Ridge athletic team, I hereby grant permission for my son/daughter to receive the appropriate medical care as deemed so by the Certified Athletic Trainer, Physician, or Coach. In the event of a serious illness or injury, I understand that every attempt will be made to contact me. I hereby grant permission to the Certified Athletic Trainer (Amberwell or otherwise) to proceed with any necessary evaluation, minor medical treatment, and rehabilitation of injuries sustained by my child.

STATEMENT OF RISK

We/I, the parents of ___________________________ do hereby acknowledge that we/I have been fully advised, cautioned and warned by the proper administrative and/or coaching personnel of USD 449 Pleasant Ridge that our/my child named above through participation may suffer serious injury including but not limited to, death, neck and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to all internal organs, serious injury to all bones, joints, ligaments, muscles, tendons, and other aspects of the musculoskeletal system, and serious injury or impairment to other aspects of your body, general health and well-being. Minor and moderate injuries are common in athletics and every participant is likely to sustain an injury during his/her athletic career. I fully know, understand, and appreciate the risks inherent in this /these sport(s) and I VOLUNTARILY participate in this activity. I hereby release all USD 449 Pleasant Ridge coaches, certified athletic trainers, team physicians, and school officials for negligence resulting in injury and liability for any injury I sustain while participating in this extracurricular activity. **I have read the above stated consent form, medical information release, and statement of risk and understand my rights as described herein. I understand my son/daughter's assumption of risk, and I authorize consent for treatment and release of my son/daughter's information, unless signed above to opt out of the medical information release. This authorization shall expire at the end of the 2025-26 school year.

Parent/Guardian Name (print):____
Parent/Guardian Signature:____
Date:_________________Cell Phone #:________________________________Email : ____