HUGHSON UNIFIED SCHOOL DISTRICT

Required to be on file for all athletes.

Student Name:_____ Date of Birth_____ School Year _____

Consent for Treatment

I hereby authorize the authorizing physicians and dentists, to evaluate and treat any injury/illness that occurs as a result of my participation in athletics. This includes reasonable and necessary preventative care, treatment and rehabilitation for these injuries/illness.

I understand that I must refrain from practice while injured/ill, whether or not receiving medical care. When under medical care, I may not return to participation until I have been given permission by a Physician, PA-C, or Certified Athletic Trainer. This may occur during or at the conclusion of medical treatment.

I understand and agree that if I experience an injury/illness or change to my health status, it is my responsibility to inform my Head Coach. I also agree to adhere to the established injury management guidelines, including rehabilitation and reassessment before I am released to return to full participation.

Authorization to Disclose Private Health Information

I grant permission to Hughson Unified School District personnel and authorized volunteers, including at Ross Middle School or Hughson High School, to disclose my Personal Health Information (written and/or verbal), when requested to do so, for the purpose of health care treatment, or for any other purpose which is required by law.

Personal Health Information includes, but is not limited to: information involving the nature and treatment of an injury/illness, medical history, insurance coverage and copies of all medical records. This information will be released ONLY for the purposes of further treatment (referrals to specialists or other health care providers), or disclosure of participation status to Hughson Unified School District personnel and authorized volunteers, including your team's coaches, for your health and safety.

Athletic Insurance Requirement

- ☐ I **DO** wish to enroll my son/daughter in the student accident insurance plan offered by the School District. See office for more information.
- ☐ I **DO NOT** wish to enroll my son/daughter in the student accident insurance plan offered by the School District.

1. My child is insured by (Insurance Carrier)_____

2. Policy # or Group Plan # _____ provides at least $10,000 insurance protection for medical and hospital expenses resulting from accidental bodily injuries incurred while participating in, practicing for, and traveling to and from athletic events. I shall maintain the above coverage during the school year and will notify the school if the coverage terminates or if the insurance carrier is changed.

3. To the best of my knowledge my child has no physical problems that would keep him/her from participating in this after school sports program.

I certify under penalty of perjury that the above information is true and correct.

Print Athlete's Name _____ Athlete's Signature _____ Date _____

Print Parent/Guardian Name _____ Parent/Guardian Signature _____ Date _____
(if student athlete is under 18)

Site to attach Aeries Emergency Card Printout

Student Name:_____ Date of Birth_____ School Year _____

PHYSICIAN'S HEALTH STATEMENT

I hereby certify that the above named student is:

- ☐ Cleared for all sports without restriction
- ☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for

_____

Not cleared

- ☐ Pending further evaluation
- ☐ For any sport
- ☐ For certain sports _____

Reason: _____

Recommendations:

_____

_____

_____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parent(s). If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Print Physician's Name _____ Physician's Signature _____ Date _____

Address: _____ Phone _____