Aurora Sports Health

Manitowoc Public School District – Wilson Middle School ("School")
Sports Medicine Emergency Information and Consent

Student's Name: _____ Date of Birth: _____
Parent/Guardian Name: _____ Phone: _____
Address: _____
Alternate Emergency Contact Name: _____ Relationship: _____
Address: _____ Phone: _____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

First, Try: ☐ Parent/Guardian ☐ Alternate Emergency Contact
Then, Try: ☐ Parent/Guardian ☐ Alternate Emergency Contact

STUDENT'S MEDICAL INFORMATION

Primary Doctor: _____ Phone: _____
Current Medications: _____
Known Allergies: _____
Other Medical Conditions: (asthma, diabetes, previous head injuries, etc. Use back of sheet if needed) _____
_____
_____ ☐ (continued on back)

Name of Medical Insurance Company or Plan: _____
Policy Number: _____ Is plan an HMO? ☐ Yes ☐ No
If plan is an HMO, what is your primary care facility? _____

MEDICAL CONSENT TO TREAT STUDENT; AUTHORIZATION TO DISCLOSE STUDENT'S MEDICAL INFORMATION

Consent may be required in order for Student to participate in an athletic program. Consent is effective until it is revoked by a parent or guardian, or until Student is no longer enrolled at the School.
If no box is checked, it is assumed that consent is NOT given. Please check all applicable.

☐ **Yes** ☐ **No** If the athletic staff determines that Student is in need of immediate medical attention beyond that which can be provided by the athletic staff at School (and, if a minor, the Student's parent, guardian, or emergency contact cannot be reached) the athletic staff may use their judgment in securing medical aid, including ambulance service and admittance to a hospital if needed.

☐ **Yes** ☐ **No** The athletic staff, including athletic trainers, coaches, or other qualified personnel may apply first aid treatment for any injury sustained during participation in athletic programs sanctioned by School; the athletic trainer may evaluate and treat other emergent or non-emergent Student injuries or medical conditions, including concussion baseline testing, brought to the athletic trainer's attention as they relate to the Student's physical activity, conditioning or injury prevention, regardless of whether or not the Student participates in athletics.

☐ **Yes** ☐ **No** If available at School, School's athletic trainer may provide appropriate treatment modalities, such as ultrasound and electronic stimulations to treat any Student injury or other medical condition.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(if student is a minor) ☐ Parent ☐ Guardian (relationship) _____

Manitowoc Public School District

Medication Consent Form

Student Name_____ D.O.B._____ School_____ Grade_____Phone_____

Prescribing Provider_____ Prescriber Phone_____Prescriber Fax_____

Parent: I request that my child receive the medication or procedure at the time indicated and as designated by his/her medical provider. I will be responsible for bringing the medication to school in a labeled original container, and for maintaining a sufficient quantity of the medication or supplies at school. School personnel have permission to communicate with the prescribing medical provider regarding use, side effects, response and contraindications of the medication or procedure results or frequency. I can revoke my permission at any time. I agree to inform the school of any changes in the medication or if the medication is stopped. I further agree to hold the MPSD and all employees harmless in any and all claims arising from the administration of the medication at school.

Parent Consent for Prescriptions/Over the Counter Medications

Medication	Route	Dose/Frequency	Time	Reason for Medication

**Parents are REQUIRED to pick up all medication at school when discontinued or at the end of the school year. Medications left after the last day of school will be properly disposed of by the School Nurse.

Printed name of Parent/Guardian _____ Signature of Parent/Guardian _____ Date _____

Prescription Medications (to be completed and signed by Health Care Provider)

Medication/Diagnosis	Route	Dose/Frequency	Time	Self-Carry	Possible Side Effects

Procedures

Name of Procedure	Dose/Frequency	Time	Start date	Stop date	Monitoring Parameters

The above orders shall be effective throughout the current school year, unless the orders are discontinued, changed or withdrawn in writing by the parent/guardian before this time elapses. Students 6th grade and above may self carry emergency medications with health care provider consent.

Physician: (Prescription Drugs Only)

Signature of Physician _____ Printed Name of Physician _____ Date _____