AUTHORIZATION TO HAVE MINORS TREATED

This form is to be completed by the parents or legal guardians of the athlete and/or managers and returned to the athlete's coach prior to, or on the first day of practice. If it is not returned the athlete will NOT be able to participate. The coach is responsible for keeping this form with them at all team functions.

If your child becomes sick or gets injured, all reasonable efforts will be made to contact you and obtain your consent for medical care. However, the situation may arise whereas a delay to obtain parental consent would result in a delay, which would increase the risk to the child's life or health. All athletic activities have potential risks and despite safety precautions, accidents and illnesses may occur.

Please fill in this form carefully and neatly. If you know you are not going to be available for an extended period of time (hospitalization, vacation, business trip, etc.), while your child is going to be participating in team functions, please notify the coach whom to contact.

Concussion Management and Awareness Act Adherence Policy: Any student or student athlete who sustains head trauma during an interscholastic sport, intramural, or physical education class and based on mechanism of injury, observation, history, unusual behavior, and reactions of the student, even without loss of consciousness, exhibits any of the following signs or symptoms: *amnesia, confusion, dizziness, headache, loss of consciousness, nausea, poor attention, poor coordination, visual disturbance, vomiting* may not return to the athletic event.

Prior to further athletic participation, the student must be evaluated and medically cleared by a medical practitioner. Follow-up after an elapsed time must be made with the athlete's private/primary physician. The school physician **must** review each case and concur so the student athlete can resume play. An individualized return to play action may be instituted before full participation is granted. The school nurse must be notified of the injury in a timely fashion to ensure proper follow-up and tracking of the concussion(s) sustained by each athlete.

*IMPORTANT" Parents/Guardians should understand that immediate return to play may not occur and their patience and understanding of the medical importance, adherence to New York State Law, and significance of head injury, is the district's number one priority.

A very small number of parents have been reluctant to complete this form for fear of "signing away the rights of a minor". I would like to assure you that every effort would be made to contact you in the case of an emergency. If you would like to provide us with any additional information, please do so on the back of this form.

Any questions, please contact me directly at 346-1211 ext. 370.

Sincerely,

Wanda Joslin

Wanda Joslin, BRCS Athletic Director

Name of Minor:_____Date of Birth: _____

Identify allergies or special conditions:_____

Does your child wear contact lenses? _____

I/We, parent(s) legal guardian(s) of the above mentioned minor, do hereby appoint:

Coach:_____Address:_____

Phone:_____Sport:_____Level:_____

to act in my/our behalf in authorizing unexpected medical care for the above named minor during the period of his/her participation

On the 20_____ Beaver River Central School_____ team.

Signature of consenting parent(s)/ guardian(s):_____

Realizing that the above mentioned coach may not be able to contact me/us by using the information on this sheet, and realizing that rapid action by the coach and emergency personnel may save my child unnecessary pain and suffering, I/We still do not want any medical procedures over and above basic emergency care performed on my/our child.

Signatures of parent(s)/guardians(s) refusing care:_____

(Everyone must fill in the remainder of this form.)
This document shall be presented to a physician, dentist, or appropriate hospital representative at such a time as emergency medical, dental, surgical care or hospitalization may be required.
Hospitalization coverage carried on the minor:

Insurance company:_____I.D. or Contact #:_____

Family physician:
Name:_____Address:_____

Phone:_____ Local Hospital Preference:_____

Parent/Guardian Name:_____

Address:_____

Home Phone:_____Work Phone:_____

Signature:_____