



# Shikellamy Youth Football and Cheerleading Inc

P.O. Box 355, Sunbury, PA 17801-0355

## ATHLETE EMERGENCY CONTACT INFORMATION

Name: \_\_\_\_\_ Grade \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone # \_\_\_\_\_ Birth Date: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Work Phone # \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Work Phone # \_\_\_\_\_

If a parent cannot be reached, who should be contacted? \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Family MD/DO: \_\_\_\_\_ Phone #: \_\_\_\_\_

Hospital of Choice (please circle): Geisinger Sunbury Evangelical Other: \_\_\_\_\_

Allergies/Medical Conditions: \_\_\_\_\_

Medications: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy/Group # \_\_\_\_\_

IN THE EVENT OF A SERIOUS OR POTENTIALLY SERIOUS MEDICAL EMERGENCY DURING WHICH I CANNOT BE CONTACTED, I GRANT PERMISSION FOR MEDICALLY TRAINED LEAGUE STAFF TO PERFORM WHATEVER SUPPORTIVE MEASURES THEY DEEM NECESSARY UNTIL SUCH TIME AS EITHER: I CAN BE CONTACTED, PROFESSIONAL MEDICAL PERSONNEL CAN ATTEND, OR TRANSPORTATION TO A REGULAR MEDICAL FACILITY CAN BE ARRANGED,

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

## PERMISSION TO TREAT

### 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 FOOTBALL OR CHEERLEADING DIRECTLY ASSOCIATED WITH SHIKELLAMY YOUTH FOOTBALL AND CHEERLEADING INC. I UNDERSTAND THAT THE MEDICAL PERSONNEL OF SHIKELLAMY YOUTH FOOTBALL AND CHEERLEADING INC 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 EXERCISED MY RIGHT TO QUESTION THE APPROPRIATE LEAGUE OFFICIALS REGARDING THIS RELEASE FORM AND ALL MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING UNDERSTOOD THE ABOVE AGREEMENT, I FREELY SIGN THIS *PERMISSION TO PROVIDE: MEDICAL TREATMENT AGREEMENT*.

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_