

LINDSEY WILSON COLLEGE
EMERGENCY MEDICAL CONSENT FORM
For athletes under the age of 18

Athlete's Name: _____ Date of Birth: _____

Sport(s): _____

Permission is hereby granted the attending physician to proceed with any medical or minor surgical treatment, x-ray evaluation, or immunizations for the above named Lindsey Wilson College student-athlete. In the event of a serious illness, the need for major surgery, or of a significant accidental injury. I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, the treatment necessary for the best interests of the student-athlete may be given.

In the event that an emergency arises during a practice session, an effort will be made to contact the parents or guardians as soon as possible. Permission is hereby granted the Lindsey Wilson College Sports Medicine Staff to provide the necessary emergency medical treatment to the athlete, prior to the athlete's referral to a physician or hospital.

Signature of Parent(s)/Guardian(s): _____

Date: _____

Name of family physician: _____

Physician Phone #: _____