

**MILAN AREA SCHOOLS DEPARTMENT OF ATHLETICS  
Medical Consent Form 2016 - 2017**

**TO BE COMPLETED BY PARENTS**

**Student / Athlete Name:** \_\_\_\_\_  
Last First (legal name)

**Address:** \_\_\_\_\_  
Street City Zip Code

**Date of Birth:** \_\_\_\_\_ **Sex:** M F **Age:** \_\_\_\_\_ **Grade in 16/17 school yr :** \_\_\_\_\_

In what school was this student enrolled last semester? \_\_\_\_\_. If this student was NOT enrolled in the Milan Area Schools last semester, what was his/her exact date of enrollment? \_\_\_\_\_.

**Parent / Guardian's Name:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_

**Work Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**In the event of an emergency, if parent cannot be contacted, please call in the following order:**

1. \_\_\_\_\_  
Name Relationship Phone (Home) Phone (Work) Phone (Cell)

2. \_\_\_\_\_  
Name Relationship Phone (Home) Phone (Work) Phone (Cell)

3. \_\_\_\_\_  
Name Relationship Phone (Home) Phone (Work) Phone (Cell)

Person(s) authorized to assist student in the absence of the parent: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Card Membership Number: \_\_\_\_\_ Hospital preferred: \_\_\_\_\_

Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examination and immunizations for the above student. In the event of a serious illness or injury, the need for major surgery, or 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 interest of the above named student may be given.

**Parent's/Guardian's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PARENT OR GUARDIAN NOTIFICATION AND CONSENT: (must be signed by parent or guardian)**

I hereby give my consent of the above high school/middle school student to participate in interscholastic athletics at Milan High School/Middle School during the current school year. I also give my consent for the disclosure to the MHSAA of information other wise protected by FERPA and HIPPA for the purpose of determining eligibility for interscholastic athletics. I agree that if it is determined that my child needs medical or dental treatment while on a field trip, I will be responsible for any such treatment determined necessary by a physician or dentist. I further agree that if the behavior or health of my child should make it necessary to send him/her home prior to the scheduled return time, I will be responsible for those expenses. I understand that by participating in interscholastic athletics my son/daughter is exposing himself/herself to the risk of serious injury, up to and including death. I, also, understand that my son/daughter is expected to adhere firmly to all established athletic policies of his/her coach, the Milan Area Schools, and the Michigan High School Athletic Association. I give permission for said student to travel on all athletic trips scheduled for his/her team. I understand that occasionally a coach may assign my high school age child to ride to an athletic event with a selected adult driver in a privately owned vehicle. In granting this permission I assume full responsibility for any damage to person or property caused by my child. I affirm that my child legitimately resides in the Milan Area Schools attendance area. I understand the Milan Athletic Code (available on line at milanareaschools.org) and agree that my son/daughter must follow the responsibilities and obligations required to participate in the Milan Athletic Program.

**Parent's/Guardian's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_