CONSENT FOR TREATMENT

I, the parent and/or legal guardian of below named student, give my legal consent and authorize any representative of USD #416 to authorize emergency medical treatment, including any necessary surgery or hospitalization, for the student named below, for any injury or illness of an emergency nature he/she incurred while participating in any Louisburg High School athletic activities by any physician or dentist licensed in accordance with the provisions of the Kansas Healing Arts Act, K.S.A. 65-2801, and any hospital.

I agree to pay and assume all responsibility for medical and hospital expenses and any emergency services incurred on behalf of my child.

I acknowledge and agree that USD #416 is not responsible for any medical, hospital expenses and/or other charges that are incurred in the medical treatment or hospitalization of my child. A photocopy of the document shall have the same force and effect as the original. If my child requires emergency medical treatment, I understand that school personnel will make a reasonable attempt to contact me to seek my permission to authorize that treatment. To facilitate contacting me, I agree to continue to provide current work and home phone numbers to the school.

WARNING-ASSUMPTION OF RISK TO ATHLETES

There are many special benefits being afforded student-athletes by the athletic programs at Louisburg High School. It must be understood that participation of athletic activities may lead to injury to student-athletes. Therefore, the purpose of this section is to make all student-athletes aware that dangers do exist and that participation is voluntary with the understanding that risks are involved. It is to be further understood that student-athletes must share in the responsibility for their own safety and the safety of others as each participates in the district athletic program.

Student's Name:	Birthdate:
Father:	Mother:
Address:	Address:
Home Phone:	Home Phone:
Work Phone:	Work Phone:
Cell Phone:	Cell Phone:

If emergency would occur at or close to home, name of doctor you wish to see your son/daughter.

Dr Name:	Dentist Name:
Address:	Address:
Office Phone:	Office Phone:
Hospital Preference:	
Insurance Company:	
Policy & Group Number:	

Student Signature:
Parent Signature: