

**Bedford, NH SAU #25  
Bedford High School  
Athletic Department**

**Consent for Treatment Form**

**DATE:** \_\_\_\_\_

Athlete's Name \_\_\_\_\_ Grade \_\_\_\_\_ Sport \_\_\_\_\_

Address \_\_\_\_\_ Home Phone # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Date Entered Grade 9 \_\_\_\_\_

Parent's Name \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Health Insurance Co. \_\_\_\_\_ Phone # \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

**In the event the parents cannot be contacted, please contact:**

Name \_\_\_\_\_ Phone# \_\_\_\_\_

Health History: \_\_\_\_\_  
\_\_\_\_\_

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

Please List All

Allergies \_\_\_\_\_

Heart Trouble \_\_\_\_\_ Date of Last Tetanus Shot \_\_\_\_\_

I hereby give permission for the care and emergency treatment of \_\_\_\_\_ by physicians, athletic trainers, coaches, EMTs, or hospital emergency room personnel for treatment for any illness or injury resulting from, or effecting, his/her athletic participation.

Preferred Physician \_\_\_\_\_

Preferred Hospital \_\_\_\_\_

This form will cover treatment for any and all offered interscholastic sports activities in which the student may participate.

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN

\_\_\_\_\_  
DATE