SCHOOL TRAVEL FORMS

In order to provide the best possible medical care for your child, a medical record will be established for him. If your child should become injured while playing sports, during school or sponsored activities, this will provide important information about him. Please complete and sign as indicated.

School: ________ Benedictine Military School ______

Athlete's Name: ______________________________ Birth Date: ____________________

Parent/Guardian Name: ____

Address: ______________________________ **Email:** ____________________

Home Phone: ____________ Work Phone: ____________ Emergency #: ____________

Primary:
Insurance Company Name: ______________________________ Policy #: ____________

☐ HMO Preferred Hospital: ______________________________

☐ PPO Primary Care Physician: ______________________________

Secondary:
Insurance Company Name: ______________________________ Policy #: ____________

☐ HMO Preferred Hospital: ______________________________

☐ PPO Primary Care Physician: ______________________________

MEDICAL CONSENT TO TREAT

The undersigned grants the representative from St. Joseph's/Candler Health System Sports Medicine Center and its employee's parental consent for your child's pre-participation screening (if applicable) and assessment/treatment of your child's injuries that he may suffer during the school year.

I give permission for the school official, chaperone, or representative of the St. Joseph's/Candler Health System Sports Medicine Center, involved in the activity with my child, to seek medical aid, render first aid if such attention is necessary in the sole discretion of said person involved. In case of emergency and when I cannot be immediately reached by telephone or otherwise, I give permission to the physician selected by the school officials to hospitalize, secure proper treatment, and order injections, anesthesia, or surgery for my child. I agree to be responsible for all medical expenses incurred in connection therewith. In the event that Benedictine incurs expenses for medical treatment, than and in that event I agree to reimburse said institution in full.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, being of lawful age hereby authorize and consent to having St. Joseph's/Candler Health System, Inc., Athletic Trainers, and/or their consulting physician(s) provide any requested medical information to other physicians, other healthcare providers, my high school coaches or school administration, intercollegiate teams, professional teams, their scouts, recruiters, or athletic trainers which directly pertains to my participation at Benedictine Military School. Said authorization to release medical information will include, but is not limited to information concerning illnesses, injuries, treatments, hospitalizations, examinations, X-rays, or other forms of diagnostic testing occurring while participating in activities at said school or athletic organization.

I understand that I may revoke this authorization by providing written notice to St. Joseph's/Candler Health System, Inc. (Sports Medicine Department). I also understand that I am waiving my right to privacy with regard to the medical records and patient identifiable information by authorizing the release of my information.

This authorization shall be valid from the date executed below until the end of the 2008-2009 school year. I understand that the release of my medical information is being carried out with my consent and so assume full responsibility.

Parent or Guardian Signature ______________________________ Date: ____________________

Student Signature ____________________ Date: ____________ Witness: ____________________