

**Brecksville-Broadview Heights High School  
PERMISSION FOR TREATMENT**

Should a medical emergency occur, we will make every effort to contact you about treatment for your son or daughter. In the event you cannot be reached, we ask that you give us permission to provide emergency treatment for:

\_\_\_\_\_ Current Sport \_\_\_\_\_ Grade \_\_\_\_\_  
*student-athlete's name* Birthdate: \_\_\_\_\_

**Please complete the following:**

Parents/Guardians: Mother \_\_\_\_\_ Father \_\_\_\_\_

Primary Address of Athlete \_\_\_\_\_

**Phone Numbers:**

Mom's Home \_\_\_\_\_ Dad's Home \_\_\_\_\_

Mom's Cell \_\_\_\_\_ Dad's Cell \_\_\_\_\_

Mom's Work \_\_\_\_\_ Dad's Work \_\_\_\_\_

Athlete's Primary Home \_\_\_\_\_ Athlete's Cell \_\_\_\_\_

Other Contact Person \_\_\_\_\_ Phone \_\_\_\_\_

**Medical Care Information:**

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

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

Dentist Name: \_\_\_\_\_ Phone \_\_\_\_\_

**Please list any current medications that the named student-athlete is taking:**

\_\_\_\_\_

**Please list any medical conditions that the named student-athlete has (ie: asthma, diabetes, allergies – please specify, etc.):** \_\_\_\_\_

\_\_\_\_\_

**Please list any recent injury or illness that the named student-athlete has had within the last year:**

\_\_\_\_\_

Please be aware that should a medical emergency occur and your son/daughter needs to be transported for treatment of injuries sustained, a copy of this Permission for Treatment form will be sent with the transport team. This sheet is to act as the athlete's emergency medical form for BBHHS.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## PERMISSION FOR TREATMENT

The following information will only be used by the BBHHS certified athletic trainer and team physician in the event that the athlete's medical condition requires further evaluation by a physician in the office setting.

Does your insurance require a referral from your PCP (primary care physician) to see a specialist/sports medicine physician? \_\_\_\_\_

Does your insurance allow your athlete to be seen by a Cleveland Clinic Physician? \_\_\_\_\_

If you answered YES to the above question, please continue filling out the paper.

If you answered NO to the above question, you may stop here.

If the athlete has been to the Cleveland Clinic Foundation in the past for anything, please provide the following information:

Athlete's Legal Name \_\_\_\_\_

CCF # \_\_\_\_\_  
(Cleveland Clinic Foundation Medical Record Number)

At the end of each school year, this form will be destroyed so that the information you provide will be kept private.