Oakton Community College
Office of Athletics, 1600 E. Golf Rd., Des Plaines, IL 60016
847-635-1753, Fax 847-635-1606

Intercollegiate Athletics Emergency Contact and Medical Consent Form

Complete and return or fax to: Oakton Community College, Office of Athletics, Attn: Lisa Bolinder

Name of Athlete _____ **Sport** _____

Address _____
City State/Zip

Social Security No. _____ **Oakton ID No.** _____ **Date of Birth** _____ **Age** _____

Home Phone _____ **Cell Phone** _____ **E-mail** _____

List two persons to contact in case of emergency:

1. Name _____ Relationship _____

Address _____
City State/Zip

Home Phone _____ Work Phone _____ Cell Phone _____

2. Name _____ Relationship _____

Address _____
City State/Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Medical Information:

1. Do you have an illness or injury that could affect your athletic performance while participating in Oakton athletics? (Not limited to, but including asthma or exercise induced asthma) ☐ Yes ☐ No If yes, please list: _____
2. Are you presently taking any medication? (Including inhaler) ☐ Yes ☐ No If yes, please list: _____
3. Do you have any allergies? ☐ Yes ☐ No If yes, please list: _____
4. Do you wear contacts? ☐ Yes ☐ No

Please read each statement and sign all sections below.

There are inherent risks and hazards when participating in intercollegiate athletics at Oakton Community College. The injuries incurred could be severe, including risk of fracture, brain injury or other catastrophic injury, even death.

I have read the above statement, and understand that there are risks and hazards inherent when participating in intercollegiate athletics at Oakton Community College. I agree to indemnify and hold harmless the College and its employees and waive my right to make claim if an injury should occur.

Participant Signature _____ Date _____

If under the age of 18, as a parent or legal guardian of _____ I hereby give my consent for his/her practice and play in intercollegiate athletic events.

Parent/Guardian Signature _____ Date _____

— *over* —

Consent for Treatment, Health Care Operations and Release of Protected Health Information - HIPAA

I _____ (print or type name) consent to the provision of care. I understand that this care may include medical treatment, special tests, exams, evaluation, treatment, and rehabilitation of athletic injuries. I acknowledge that no guarantees have been given to me as to the outcome of my examination or treatment and all results of any examination and/or treatment are kept confidential. I understand and agree that others may assist or participate in providing care. This may include, but not be limited to, team/school/family physician, school nurse, and licensed physical therapists. Also, under the direction of a certified athletic trainer may include college student athletic trainer aides.

I authorize the Oakton Community College Athletic Trainer to provide information related to my care to be provided to the family/school/team physician, school nurse, coaches, athletic directors, school administrators, EMS personnel, and such persons as needed for them to provide consultation, treatment, and establish a plan of care. In the event of needed emergency medical care, I give my permission for a representative of Oakton Community College or an ambulance service to transport me to the nearest medical facility and for the staff of that facility to render treatment.

I authorize Oakton's Athletic Trainer to release medical information necessary to arrange appointments and process my insurance claim. I understand that my primary insurance guidelines must be followed and failure to do so may result in denial of secondary insurance benefits. Oakton Community College is not responsible for unpaid medical expenses.

Athlete Signature _____ Date _____

Printed Name of Athlete _____ Sport(s) _____