WASATCH
SPORTS ACADEMY

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Medical Treatment Consent and Emergency Information

Complete one for each athlete. Update it every season and any time something changes. Shared only with staff who need it for the athlete's safety.

1. Athlete

Athlete's full legal name _____ Preferred name _____ Date of birth _____

Sport / team / practice block _____ Season _____

2. Parents / guardians and emergency contacts

Name	Relationship	Mobile phone	Other phone	Authorized pickup?

WSA calls 911 first in an emergency, then the people above in order.

3. Allergies

☐ No known allergies

Allergen (food, medicine, insect sting, latex, other)	Reaction	Severity (mild / moderate / severe)	What to do

4. Medical conditions

Check any that apply and explain below:

☐ Asthma ☐ Diabetes ☐ Seizure disorder ☐ Heart condition

☐ Prior concussion (date: ___) ☐ Sickle cell trait/disease ☐ Bleeding disorder ☐ Heat illness history

☐ Recent surgery / injury ☐ Vision / hearing ☐ Behavioral / sensory needs ☐ Other

Details, limitations, and anything coaches should know

5. Medications

Medication	Dose / when taken	Needed at practice? (Y/N)	Carried by athlete or parent?

- ☐ My child may carry and use their own emergency medication (for example an inhaler or epinephrine auto-injector) as prescribed.
- ☐ I have attached an action plan from my child's health care provider (asthma, allergy/anaphylaxis, seizure, diabetes).

WSA coaches and staff do not give prescription or over-the-counter medication except as stated in an attached written plan from the child's health care provider.

6. Physician and insurance

Physician / clinic name

Phone

Health insurance carrier (optional)

Member ID (optional)

Group # (optional)

Policyholder name (optional)

Preferred hospital (if any)

7. Consent to emergency treatment

I am the parent or legal guardian of the athlete. I authorize WSA coaches and staff to give basic first aid. If my child needs urgent care and I cannot be reached right away, I authorize WSA to call 911 and I consent to emergency medical personnel and licensed health care providers evaluating, treating, and transporting my child, including treatment they believe is necessary in an emergency. WSA will keep trying to reach me or an emergency contact. I authorize WSA to share this form with emergency responders and treating providers. If a concussion is suspected, my child will be removed from play and will not return until WSA receives written clearance as described in the Concussion Acknowledgment (Utah Code § 26B-4-404). I am responsible for all costs of medical care. WSA does not provide health insurance. I confirm this information is accurate and complete, and I will update it in the Portal or in writing if anything changes. I understand that WSA is not a health care provider and is not covered by HIPAA, and that WSA protects this information under its Privacy Policy and shares it only with staff who need it for my child's safety.

Parent / guardian signature

Printed name

Date

Second parent / guardian (optional) signature

Printed name

Date

Office use: Received _____ Medical alert added to roster ☐ Action plan on file ☐ Staff initials _____ Form version: v1 · Effective October 6, 2026