The student and parent/guardian further consent and authorize the school's AHCT to administer baseline and/or post injury concussion management assessment in order to manage a concussion or suspected head trauma, such care to be conducted under the direction of a physician.

The student and parent/guardian hereby consent to the release of medical information by physician to the school for purposes of allowing the school to obtain information regarding the medical history, records of injury or surgery, serious illness, and rehabilitation results of the student from his/her physician(s). We understand that the purpose of this request for medical information is to assist the school in management or rehabilitation of an injury/illness. This information is normally confidential and except as provided in this release will not be otherwise released by the parties in charge of the information. This release shall remain valid until revoked by the adult student or parent/guardian in writing.

The student and parent/guardian expressly agree that this assumption of risk and release agreement is intended to be as broad and inclusive in favor of the State of Hawaii as permitted by the laws of the State of Hawaii and that if any provision herein is held to be invalid, it is agreed that the remaining provisions shall, notwithstanding, continue in full force and effect.

The parties understand and agree that this agreement is made with full knowledge of the facts and legal implications of entering into such an agreement and they further agree that this agreement contains the entire agreement between the parties, hereto, and that the terms of this agreement are contractual and not mere recitals.

The laws of the State of Hawaii shall control this agreement.

IN WITNESS WHEREOF, the parties hereby execute this agreement, effective the date first indicated in this agreement.

_____ Signature of Student

_____ Signature of Adult Student

_____ Signature of Parent/Guardian

EMERGENCY INFORMATION:

Student's Name _____ Home Telephone _____

Father's/Guardian's Name _____ Bus. Phone _____ Cell or Pager # _____ Employer _____

Mother's/Guardian's Name _____ Bus. Phone _____ Cell or Pager # _____ Employer _____

Medical Condition (allergies, prescription medicine, etc.) school should know about my child _____

_____

Health and/or Insurance Carrier _____ Policy # _____

When the listed student becomes ill or incurs an injury during a school-sponsored activity and I am unable to be contacted, the school authorities have my permission to contact and release the student to the custody of any of the following persons:

Name	Relationship	Home Telephone	Business Telephone
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family Physician Phone _____ Phone _____

Preferred hospital/clinic _____

To ensure prompt attention to your child, PLEASE NOTIFY SCHOOL ATHLETIC DEPT. OF ANY CHANGE IN PHONE NUMBERS OR ADDRESS.

Signature of Parent/Guardian or Adult Student _____ Date _____

ALL INFORMATION ON THIS CARD MUST BE COMPLETED FOR PARTICIPATION ELIGIBILITY.

For Official Use Only

Physical Date: _____

Processing Fee: _____

SY: _____ CMP: Y N