# KEYSTONE SCHOOL DISTRICT
# PERMISSION FOR MEDICAL TREATMENT

**In the event of an emergeny requiring medical attention, I hereby grant permission to the certified athletic trainer, physician, or other hospital personnel designated by the District Coaching Staff and/or Administration to attend to my son/daughter.**

**I expect every effort will be made to contact me in order to receive my specific authorization before any treatment or hospitalization is undertaken.**

Student Name _____ DOB _____ Grade _____

Parent/Guardian Name _____

Parent Home Phone _____ Parent Cell Phone _____

Parent/Guardian Email _____

Parent/Guardian Signature _____

**IF PARENT/GUARDIAN CANNOT BE REACHED CONTACT:**

_____ Phone: _____

## HEALTH HISTORY

| | YES | NO |
|---|---|---|
| Allergies | | |
| Medications | | |
| Heart Condition | | |
| Back/Spinal Problems | | |
| Kidney Injuries | | |
| Glasses | | |
| Contacts | | |
| Dentures | | |
| Seizure Disorders | | |

Blood Type _____

IF ALLERGIES OR MEDICATIONS, PLEASE LIST:

_____

_____

FAMILY DOCTOR _____

PHONE # _____

INSURANCE CO _____

SPORTS INVOLVED IN

_____

_____