KEYSTONE SCHOOL DISTRICT

PERMISSION FOR MEDICAL TREATMENT

In the event of an emergency requiring medical attention, I hereby grant permission to the certified athletic trainer, physician or other hospital personnel designated by Keystone School District Coaching Staff and/or Administration to attend to my child/ward.

ATHLETE INFORMATION: **18-19 Grade**

NAME _____ DOB _____ _____

Parent/Guardian Information:

Name(s) _____ Preferred Phone Number: _____

Email _____

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

Parent Signature _____

IF PARENT/GUARDIAN CANNOT BE REACHED CONTACT:

NAME: _____ Relationship: _____ Phone: _____

ATHLETE HEALTH HISTORY

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

List Allergies: _____

List Medicine: _____

Blood Type, If Known _____

Family Doctor _____

Phone # _____

Insurance Co. _____

Sports Involved In:

Fall: _____

Winter: _____

Spring: _____