ATHLETIC EMERGENCY/PERMIT FORM

TO THE PARENTS: Please complete this form. It will help us give immediate aid in case of sudden illness or injury at a game/practice.

NAME_____GRADE (circle) 7 8

ADDRESS_____CITY_____PHONE_____

FATHER_____MOTHER_____

PLACE OF EMPLOYMENT (father)_____PHONE._____

PLACE OF EMPLOYMENT (mother)_____PHONE._____

NEIGHBOR AND RELATIVE (or friend) TO BE CALLED IN CASE UNABLE TO REACH PARENTS

NEIGHBOR_____PHONE _____

RELATIVE (friend)_____ PHONE _____

PHYSICIAN_____PHONE_____

DENTIST_____PHONE_____

TO WHOM IT MAY CONCERN:
I, the undersigned, being the parent or legal guardian of_____do hereby grant to any hospital, emergency center, doctor, nurse, and/or paramedic, authorization to grant treatment to my child, when accompanied by or escorted to the treatment facility by a teacher, coach, teacher's aide, principal or any member of the Collinsville Unit School District #10 Board of Education
Further, should the attending physician determine after examination that life-saving surgery procedures might be necessary, permission is hereby extended to the above parties to grant same.
Additionally, I agree to hold harmless such personnel and the Collinsville Unit #10 Board of Education by my action of granting said permission.

_____ _____
Signature of Parent/Guardian of above-named student Date

ADDITIONAL HEALTH INFORMATION

PLAYERS AND PARENTS SHOULD ANSWER THE FOLLOWING QUESTIONS VERY CAREFULLY TO EXPEDITE TREATMENT SHOULD AN EMERGENCY OCCUR. ALL INFORMATION WILL BE CONFIDENTIAL.

1. Are you allergic to any medications (aspirin, penicillin, sulfa, etc.)? List. YES NO

_____

2. Do you take ANY prescribed medications on a permanent or semi-permanent basis (antibiotics, anti-inflammatory, etc.)? List. YES NO

_____

3. Have you ever been told by a doctor that you have asthma? List medication(s). YES NO

_____

4. Do you have any other conditions we should be aware of (insect or food allergies, tendinitis, etc.)? YES NO

_____

5. Date of last Tetanus shot_____

INSURANCE CO._____POLICY NO._____

GROUP NO._____ INS. CO. PHONE#_____

PRIMARY PERSON INSURED_____