PERMISSION FOR MEDICAL TREATMENT

Athlete's Name:______________________________ Grade:__________

Sports:____

Parent(s)/Guardians(s):____

Phone (H):____________________ Phone(W):________/__________

Physician(s):___________/____________ Phone:__________________

Special Medications/Allergies:_______________________________________

____

Have you ever seen a specialist?_________ Whom?____________________

For what/when?____

____

Is there anything else your coach should be aware of concerning your medical

history?____

____

Please list two emergency contacts other than parent/guardian.

Name:______________ Relation:______________ Phone:______________

Name:______________ Relation:______________ Phone:______________

In the event of an emergency requiring medical attention, I hereby grant permission for emergency treatment for my son/daughter. I expect an effort will be made to contact me in order to receive my specific authorization before emergency room treatment is undertaken. I understand that the cost for any medical attention is NOT covered by Tri-County H.S., Marshall County Central H.S., or the Minnesota State High School League.

Signed:______________________________ Date:______________

THIS FORM WILL BE TAKEN TO ALL EVENTS