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

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

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

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

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5. Date of last Tetanus shot________________.

INSURANCE CO.______________________________ POLICY NO.______________

GROUP NO.__________________ INS. CO. PHONE#______________________

PRIMARY PERSON INSURED____