

**CHESTER-JOPLIN-INVERNESS PUBLIC SCHOOLS
MEDICAL/ATHLETIC CONSENT FORM K-12**

In the event of an accident, injury, or emergency, I understand that a reasonable attempt will be made to contact me as the parent or guardian of the above named student. However, if the school is not able to contact me, permission is hereby granted to seek the emergency medical treatment necessary for the best interest of the above named student. Medical expenses are the parents/guardians financial responsibility. In case of an emergency or disaster, all students will be at the Lutheran Church Fellowship Hall.

Signature of Parent or Guardian _____
Date

Phone number where parents may be reached:

Office: _____ Name of Family Physician: _____
Home: _____ Phone Number: _____
Cell: _____ Parent Email Address: _____
Mailing & Physical Address: _____
Other: _____

Two local emergency contact numbers if parents cannot be reached:

Name and Relationship: _____
Phone: _____

Name and Relationship: _____
Phone: _____

Student Name: _____

Health History	Yes	No		Yes	No
Asthma	___	___			
Kidney injuries	___	___	While competing, do you wear:		
Heart condition or disease	___	___	_____Glasses	___	___
Diabetes	___	___	_____Contacts	___	___
*Allergy (medication/foods)	___	___			

Please state:

_____ The above student has my permission to participate in the following activities for the current school year:

___ Basketball	___ Tennis	___ 4-5 Basketball
___ Football	___ Track	___ Wrestling
___ Volleyball	___ Speech & Drama	

Student Name: _____

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Asthma	___	___			
Kidney injuries	___	___	While competing, do you wear:		
Heart condition or disease	___	___	_____Glasses	___	___
Diabetes	___	___	_____Contacts	___	___
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