Student's Name	
School	
I certify that requirements to try out for a football/basketball/vol understand this form legally releases all obligations of my son/daughter in the event of illness or injury parent cannot be reached. If there is any physical of participate fully, the school requires a doctor's releany injury incurred during tryouts.  Parent(s)' Signature:	is physically capable and able to fulfill leyball/track/cheerleading position. Is and responsibilities for the medical treatment during any squad related activity when either or medical reason why she/he should not ase. Furthermore, the school is not liable for
MEDICAL TREATMENT PERMISSION FOR	
In the event of an emergency occurring while my s performance, or trip, I grant my permission to the saction necessary. In the event that I cannot be reactive employees to give consent for my son/daughter: to receive medical treatment.	school and its employees to take whatever hed, I hereby authorize the school and/or
Home Phone:Bu	siness Phone:
Address:City:	
City:	State:Zip:
Person to be notified other than parent or guardian Name: Family Doctor:	in an emergency: Phone: Phone:
If you do not grant permission or authorization for should be followed?	consent to medical treatment, what procedure
Insurance Company:	Policy #:
Parent/Guardian Signature:	Date:
Medical Information: circle one Heart condition or disease YES NO Diabetes YES NO Convulsions disorder YES NO	Asthma Allergic to medication Allergic to insect stings  YES NO YES NO YES NO
State allergies:	
Date of last tetanus shot:	1.
Additional medical information that may be helpfu	1:
Any medications currently receiving	

Student's Name								
School			Grade					
I certify that requirements to try out for a understand this form legally of my son/daughter in the exparent cannot be reached. It participate fully, the school any injury incurred during to Parent(s)' Signature:	footbal release vent of i f there is requires	l/basketba s all oblig llness or i s any phys s a doctor'	is physical ill/volleyball/track/checations and responsibilingury during any squadical or medical reasons release. Furthermore	ly capable an erleading posties for the native action why she/he action, the school	nd able sition. nedical wity whe should is not li	to fulfill I treatment en either		
MEDICAL TREATMENT								
In the event of an emergence performance, or trip, I grant action necessary. In the eve its employees to give conser to receive medical treatment	my per int that I nt for m	mission to cannot be y son/dauş	the school and its empereached, I hereby authors.	ployees to tal norize the sc	ke what hool an	d/or		
Home Phone:		*	Business Phone:					
Address:City:			State	7:				
Person to be notified other to Name: Family Doctor:  If you do not grant permission should be followed?	on or au	thorizatio	Phone: Phone: n for consent to medica	al treatment.				
						<del></del>		
Insurance Company:Parent/Guardian Signature:_			Polic	cy #: Date:				
Diabetes Convulsions disorder	YES YES YES		Asthma Allergic to medi Allergic to insec	et stings	YES YES YES	NO NO NO		
Any medications currently r	eceiving	<b>o</b> :						

Student's Name						
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MEDICAL TREATMENT						
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Home Phone:			B	usiness Phone:		
Address:						
Address:				State: Zi	p:	
Person to be notified other t Name:	han pare	ent or g	uardiar	in an emergency.		
If you do not grant permissi should be followed?	on or au	thoriza	tion for	consent to medical treatme	nt, what p	rocedure
Insurance Company:Parent/Guardian Signature:_				Policy #:		
Taroni Gaardian Dignatare.		*		Date:_		
Medical Information: circle	one					
Heart condition or disease	YES	NO		Asthma	YES	NO
Diabetes	YES	NO		Allergic to medication	YES	NO
Convulsions disorder	YES	NO		Allergic to insect stings	YES	NO
State allergies:						
Date of last tetanus shot						
Additional medical informa	tion that	may b	e helpfi	ıl:		
Any medications currently r						
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Student's Name						
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MEDICAL TREATMENT	Γ PERN	IISSION :	FORM			
performance, or trip, I grant action necessary. In the ever its employees to give consert to receive medical treatment	my per ent that I nt for m	mission to cannot be y son/daug	my son/daughter is in school s the school and its employees reached, I hereby authorize the thter:	to take wha ae school an	tever d/or	
Address.			Business Phone:			
City:			State:	7:		
raimly Doctor:	on or au	thorization	Phone: Phone:  or for consent to medical treatm			
Insurance Company:Parent/Guardian Signature:_			Policy #: Date	:		
Diabetes Convulsions disorder State allergies:	YES YES YES	NO NO NO	Asthma Allergic to medication Allergic to insect stings	YES YES YES	NO NO NO	
Date of last tetanus shot:						
Additional medical informa	tion that	may be he	elpful:			
Any medications currently r	eceiving	<u> </u>				

Student's Name								
School			Grade					
understand this form legally of my son/daughter in the exparent cannot be reached. It	release release vent of if there is requires ryouts.	I/basketbas all oblig llness or i s any phys s a doctor'	is physically capa all/volleyball/track/cheerleadi ations and responsibilities for njury during any squad relate sical or medical reason why s s release. Furthermore, the se	able and able ng position. The medical d activity whether should	to fulfill I treatment ten either not iable for			
MEDICAL TREATMENT	r pern	<b>IISSION</b>	FORM					
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Home Phone:			Business Phone:					
Address:		-	State:					
Person to be notified other to	han pare	ent or guar						
	on or au	thorizatio	n for consent to medical treat					
Insurance Company:Parent/Guardian Signature:_			Policy #: Dat	e:				
Medical Information: circle Heart condition or disease Diabetes Convulsions disorder	one YES YES YES	NO NO NO	Asthma Allergic to medication Allergic to insect sting		NO NO NO			
State allergies:								
Additional medical information	tion that	may be h	elpful:					
Any medications currently r	eceiving	j.			· · · · · · · · · · · · · · · · · · ·			

Student's Name							
School	Grade						
I certify that requirements to try out for a funderstand this form legally rof my son/daughter in the ever parent cannot be reached. If the participate fully, the school reany injury incurred during try Parent(s)' Signature:	cootbal eleases ent of in there is equires	l/baske s all ob llness c s any pl a doct	tball/voligation r injury hysical or's rele	is physically lleyball/track/cheerl and responsibilitie during any squad representation where the formedical reason where the formed is a second to the formed in the form	capable an eading pos s for the m elated activ ny she/he s he school i	d able ition. edical wity when the should so not list	to fulfill I treatmented the rection of
MEDICAL TREATMENT							
In the event of an emergency performance, or trip, I grant maction necessary. In the event its employees to give consent to receive medical treatment.	ny peri t that I	nissior cannot	to the	school and its emplo thed, I hereby author	vees to tak	e what	ever
Home Phone:			Bı	siness Phone:			
Address:City:							
City:			·	State:	Zip:		
Person to be notified other that Name:  Family Doctor:	an pare	nt or g	uardian	in an emergency:			
If you do not grant permission should be followed?	or au	thoriza	tion for	consent to medical t	reatment, v	what p	ocedure
Insurance Company: Parent/Guardian Signature:				Policy :	#: Date:		
Diabetes Convulsions disorder	YES YES YES		e helpfu		tings		
Any medications currently rec	eivino	:			,		