Permission for Medical Treatment

Athlete Name:____Grade:______________

Sport(s):____

Parent(s)/Guardian:____

Phone: (H):____________________(W):_____________________(C):_____________________

(H):____________________(W):_____________________(C):_____________________

Physician:____________________________________Phone:___________________________

Special
Medications/Allergies:____

____

____

Have you ever seen a specialist? Y N Whom?__________________________________

Forwhat/when?____

____

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

____

____

Please list two emergency contacts other than a parent/guardian.

Name:______________________________________Relation____________________________

Phone (H):____________________(W):_____________________(C):_____________________

Name:______________________________________Relation____________________________

Phone (H):____________________(W):_____________________(C):_____________________

**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 Marshall County Central High School or the Minnesota State High School League.

Parent/Guardian
Signature:____Date:__________________