MEDICAL TREATMENT
PERMISSION FORM

In the event of an emergency occurring while my son is on a team sponsored practice or trip, I grant permission to the team to take whatever action necessary. In the event that I cannot be reached, I hereby authorize the team to give consent for my son/ daughter,_____ to receive medical treatment.

Home Phone:_____ Business Phone_____
Father's cell_____ Mother's cell_____
Address_____
City_____ State_____ Zip Code_____

Person to be notified other than parent or guardian in an emergency:
Family Doctor_____ Phone_____

If you DO NOT grant permission or authorization for consent to medical treatment, what procedure should be followed?

Insurance Company_____ Policy #_____

_____ _____
Date Parent Signature

MEDICAL INFORMATION
(Circle One)

Heart Condition or disease	**yes**	**no**
Diabetes	**yes**	**no**
Convulsions disorders	**yes**	**no**
Asthma	**yes**	**no**
Allergic to medication	**yes**	**no**
Allergic to insect stings	**yes**	**no**

State allergies_____
Date of last Tetanus shot_____
Additional medical information that may be helpful_____

PLEASE ATTACH A COPY OF YOUR INSURANCE CARD