_____

Sport and Level

Permission for Medical Treatment

I hereby grant permission to the Athletic Training Staff (Athletic Trainer, Coach, Team physician, Team Chiropractor, Paramedics, and/or the Emergency Room Physician) at Rancho Buena Vista High School to evaluate my son/daughter if any injury or illness should occur during a team practice or game. I understand that if an injury/ illness should occur the Athletic Training Staff would give me the necessary recommendations, referrals or course of treatment. I also understand that is a medical emergency should occur every effort would be made by the Athletic Training Staff to contact me with the information that I give below.

(Please Print Clearly)

_____

Parent Signature

Student's First and Last Name **Age** **Grade**

_____ _____

Mother's Name or Guardian Father's Name or Guardian

_____ _____

Mother's Cell Phone or Guardian Father's Cell Phone or Guardian

_____

Student's Home Address City Home Phone Number

1._____

Non Parent Emergency Contact Relationship Phone Number

2._____

Non Parent Emergency Contact Relationship Phone Number

_____

Insurance Carrier Policy Number Student's Birth date

Health History

Medical Conditions – If answered "yes," please describe.

Kidney injures/ Heart Conditions/ Diabetes yes no _____

Contact Lenses / Glasses . . . . . yes no _____

Asthma . . . . . yes no _____
(If yes, medication being used at this time) ** athlete may supply athletic trainer with an inhaler**

Allergies . . . . . yes no _____
(Please list all – environmental or to medications)

Medications currently using: _____

Any other Concerns: _____

_____