WESTHILL HIGH SCHOOL

PERMISSION FOR MEDICAL TREATMENT

ATHLETE'S NAME: _____

SPORT: _____

In the event of an emergency requiring medical attention, I hereby grant permission for a physician or other hospital personnel designated by the STAMFORD PUBLIC SCHOOLS coaching staff to attend to my son/daughter. I expect every effort will be made to contact me in order to receive my specific authorization before any further treatment or hospitalization is undertaken.

_____

SIGNED DATE

ADDRESS_____

HOME PHONE _____

CELL PHONE_____

WORK PHONE_____

HEALTH HISTORY

FAMILY DOCTOR _____

PHONE NUMBER_____

FAMILY DENTIST_____

PHONE NUMBER_____

KIDNEY INJURIES Y___ N___
HEART CONDITION OR DISEASE Y___ N___
ASTHMA Y___ N___

DATE OF LAST TETANUS SHOT_____
MEDICATIONS_____

WHILE COMPETING DO YOU WEAR:
GLASSES Y___ N___ CONTACTS Y___ N___

ALLERGY TO ANY MEDICATION:
PLEASE STATE_____

Physical Date on file _______________
(Phys. Expires 13 months from date)