Radnor Township School District

Permission from Parent/Guardian for Medical Treatment

School Year: ________________ Sport: ____________________________

__________________________, ___________________ ____________ ____________

Last Name First Name Grade Birthdate

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Street Address City State Zip Code

As a parent/guardian, I expect every effort will be made to contact me to receive my specific authorization before any treatment or hospitalization is undertaken.

Mother's Home #:_________________________ Father's Home #: _________________________
Mother's Work #: _________________________ Father's Work #: _________________________
Mother's Cell # : _________________________ Father's Cell # : _________________________
Mother's Email: _________________________ Father's Email : _________________________

If parent/guardian cannot be reached, call:

1st : ____________________________________ ____________________ ____________

Name Phone # Relationship

2nd : ____________________________________ ____________________ ____________

Name Phone # Relationship

In the event of an emergency requiring medical attention, I grant permission to a physician or other medical personnel designated by the Radnor coaching staff to attend my son/daughter.

_________________________________ _________________________________ _____________

Print Name of Parent/Guardian Signature of Parent/Guardian Date

Family Physician: ________________________________ Tele #: ___________________________
Dentist : _______________________________________ Tele #: ___________________________

INSURANCE COVERAGE:

You are required to provide medical insurance coverage in order to participate in our interscholastic program. This certifies my child has proper and adequate coverage.

_________________________________ ____________________ ____________________

Insurance Company Policy # Group #

Subscriber's Name: _____________________________________ Subscriber's SS #: _________________

Is your child allergic to any medication (if so, which)?____
Is there any medical condition that a physician should be aware of (e.g. asthma, diabetes, heart condition, kidney injury, contacts, etc.)? ____

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