

PERMISSION FOR MEDICAL TREATMENT

In the event of an emergency requiring medical attention, I hereby grant permission to a physician or other hospital personnel designated by the Keene High School Coaching Staff to attend my son/daughter _____

(Name)

I expect every effort will be made to contact me in order to receive my specific authorization before any treatment or hospitalization is undertaken.

Signed _____ Address _____

Home Phone _____ Cell Phone _____

Bus. Phone _____ Date _____

Insurance Information _____

Parent/Guardian Email _____

Student's Physician _____ Phone # _____

HEALTH HISTORY

	<u>Yes</u>	<u>No</u>	
Kidney injuries	_____	_____	Date of last Tetanus shot:
Heart condition or disease	_____	_____	_____
Diabetes	_____	_____	Date of birth:
Asthma	_____	_____	_____
While competing do you wear:			
Glasses	_____	_____	
Contacts	_____	_____	
Allergy to any medication	_____	_____	

Please state: _____
