

# KEYSTONE SCHOOL DISTRICT PERMISSION FOR MEDICAL TREATMENT

In the event of an emergency requiring medical attention, I hereby grant permission to the certified athletic trainer, physician, or other hospital personnel designated by the District Coaching Staff and/or Administration 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 treatment or hospitalization is undertaken.

Student Name \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Signed \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ Business Phone \_\_\_\_\_

**IF PARENTS CANNOT BE REACHED THEN CALL \_\_\_\_\_ PHONE \_\_\_\_\_**

Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Co. \_\_\_\_\_

## HEALTH HISTORY

	YES	NO
Allergies		
Medications		
Heart Condition		
Back/Spinal Problems		
Kidney Injuries		
Glasses		
Contacts		
Dentures		
Seizure Disorders		

IF ALLERGIES OR MEDICATIONS, PLEASE NAME:

\_\_\_\_\_

\_\_\_\_\_

Blood Type \_\_\_\_\_