

Authorization for Medical Services

Student Name _____ Grade ____ Age ____

SCHOOL YEAR _____ SPORTS _____ / _____ / _____

As legal guardian for the student indicated above. I give my permission for necessary medial services to be administered to the student in case of illness or accident. Every attempt will be made to contact the parent/ guardian should we need to seek medical services.

Parent/ Guardian Signature: _____ Date: _____

Address: _____

Phone: Home/Cell: _____ Work: _____

Student's Physician: _____ Office Phone: _____

Insurance Carrier: _____

Policy Number: _____

Allergies or Special Concerns: _____

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