WARREN-ALVARADO-OSLO HIGH SCHOOL
PERMISSION FOR MEDICAL TREATMENT FORM – 2018/2019

THIS FORM WILL BE TAKEN TO ALL SPORTING EVENTS

- please use dark blue or black ink -

Student Name_____Grade_____

Sports_____

Parent(s)/Guardian(s)_____

Home Phone_____ Cell Phone_____

Work Phone_____ Cell Phone_____

Physician Name & Number_____

Special Medications/Allergies_____

_____

Have you ever seen a specialist_____Whom_____

For what/when_____

_____

Is there anything else your coach should be aware of concerning your medical history

_____

Please list two emergency contacts other than parent/guardian

Name_____Relation_____Phone_____

Name_____Relation_____Phone_____

In the event of an emergency requiring medical attention, I hereby grant permission for emergency treatment for my son/daughter. I expect an effort will be made to contact me in order to receive my specific authorization before emergency room treatment is undertaken. I understand that the cost for any medical attention is NOT covered by Warren/Alvarado/Oslo High School or the Minnesota State High School League.

Signed_____Date_____