

COLLINSVILLE HIGH SCHOOL ATHLETICS INFORMATION SHEET

STUDENT INFORMATION:

FULL NAME _____ Birth Date: _____

GRADE 9 10 11 12 SPORT _____ COACH _____

HOME ADDRESS _____
(Street, City, State & Zip)

MEDICAL INFORMATION:

ALLERGIES _____ MEDICATIONS _____

EXISTING MEDICAL CONDITIONS/CONCERNS _____

PARENT/GUARDIAN INFORMATION:

Adult No. 1

RELATIONSHIP FATHER MOTHER GUARDIAN GRANDPARENT OTHER - _____

FULL NAME _____

HOME ADDRESS _____
(Street, City, State & Zip)

WORK PHONE _____ CELL PHONE _____
(Include Area Code) (Include Area Code)

Adult No. 2

RELATIONSHIP FATHER MOTHER GUARDIAN GRANDPARENT OTHER - _____

FULL NAME _____

HOME ADDRESS _____
(Street, City, State & Zip)

WORK PHONE _____ CELL PHONE _____
(Include Area Code) (Include Area Code)

MEDICAL AUTHORIZATION

TO WHOM IT MAY CONCERN:

I, the undersigned, being the parent or legal guardian of _____ do hereby grant to any hospital, emergency center, doctor, nurse, and/or paramedic authorization to grant treatment to my child, when accompanied by or escorted to the treatment facility by a teacher, coach, teacher's aide, principal or any member of the Collinsville Unit District #10 Board of Education. Further, should the attending physician determine after examination that life-saving surgery or other life saving procedures might be necessary; permission is hereby extended to the above parties to grant it. Additionally, I agree to hold harmless such personnel and the Collinsville Unit District #10 Board of Education by action of granting said permission.

Signature of Parent/Guardian of Above-Named Child Date