Radnor Township School District
Permission from Parent, Guardian for Medical Treatment

School Year: _____ Sport _____

_____ _____ _____ _____
Last Name First Initial Grade School District Student Birthdate

As a parent/guardian I expect every effort will be made to contact me in order to receive my specific authorization before any treatmen or hospitalization is undertaken.

Home Phone _____ Father's Work # _____ Mother's Work # _____

Cell # _____ Father _____ Mother_____

_____
Street Address City State Zip

If Parent cannot be reached call:

1._____
Name Tele # relationship

2._____
Name Tele # relationship

In the event of an emergency requiring medical attention, I grant permissison to a physician or other hospital personnel designated by the Radnor coaching staff to attend my son/daughter.

_____ _____ _____
Print Parent/Guardian Name Signature Parent/Guardian Date

Family Physician _____ Tele # _____ Dentist _____ Tele # _____

INSURANCE COVERAGE:

You are required to provide medical insurance coverage in order to participate in our interscholastic program. This certifies that my child has proper and adequate coverage.

_____
Insurance Company Policy No. Group No.

Subscriber SS #_____ Subscriber Name _____

Does your child wear: contacts/ glasses Has you child ever had: asthma/ diabetes / kidney injury / heart condition
If yes, please explain: _____

Is your child allergic to any medication? _____

Is there any condition other than stated above, that a physician should be aware of? _____

Has your child ever repeated a grade after 6th grade: (circle) 7th 8th 9th 10th 11th 12th

White - Coach Canary - Trainer

RTSD-124 NCR