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 treatment or hospitalization is undertaken.

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

Street Address City State Zip

If Parent cannot be reached call:

1. _____
Name Tele # relationship

2. _____
Name Tele # relationship

RTSD-124

In the event of an emergency requiring medical attention, I grant permission 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