Saline Area Schools
Community Education Department

Medical Information

Today's Date: _____ Class/Sport:_____

Name:_____ Birth Date: ____ / ____ / ____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Mother/Guardian's Name: _____Phone: _____Work/Cell Phone: _____

Father/Guardian's Name: _____Phone: _____Work/Cell Phone: _____

If parents can't be reached, please list two other adults that may be contacted:

Name: _____Relationship: _____Phone:_____

Name: _____Relationship: _____Phone:_____

Please list all medical information of which the teacher/coach should be aware of while supervising your child (i.e. allergies, epilepsy, asthma, diabetes, heart condition, medications, etc.)

_____

_____

_____

Medical Consent

Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examination, and immunizations for the child named. In the event of serious illness, the need for major surgery or significant accidental injury, I understand that an attempt will be made by the attending physician to contact the parent or guardian in the most expeditious way possible. If said physician is not able to reach a parent or guardian, the treatment necessary for the best interest of the child may be given.

In the event that an emergency arises during classes, games or practices, an effort will be made to contact the parent as soon as possible.

Participants are not insured by Saline Area Schools or Community Education. Parents are responsible for all medical expenses incurred.

I have read, understand, and agree to the above statements: _____
(signature of parent or guardian)

Name of participant's health insurance company: _____