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 # _____

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 Pink - Athletic Dept.

RTSD-124 NCR