



MATANZAS HIGH SCHOOL

ATHLETICS and SPORTS MEDICINE

CURRENT SCHOOL YEAR: 202 /202

GRADE: _____

As parent and/ or guardian of _____, a minor, I hereby, authorize the treatment by qualified and licensed medical practitioners (Certified Athletic Trainers, Physicians, and other emergency medical personnel) in the event of a medical emergency which, in the opinion of the attending medical provider, may endanger my child's life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me. I further authorize that my child may be transported to a hospital or emergency clinic for treatment. **FORM MUST BE COMPLETE.**

Athlete's Name: _____ Date of Birth: _____
Sports interests: _____ Graduation Year: _____
Parent/Guardian: _____ Email: _____
Address: _____ City: _____ State: FL Zip: _____
Daytime Ph. (____) _____ Evening Ph. # (____) _____ Cell#(____) _____
Family Physician: _____ Phone # (____) _____
Insurance Comp: _____ Policy # _____

Voluntary Health Insurance Info available in Athletics or at WWW.STUDENTINSURANCE-KK.COM

IMPORTANT- answer YES or NO no check marks or X answers

Indicate specific medical allergies, chronic illnesses, or medical conditions that coaches and medical personnel should be aware of: _____

Is student allergic to any drugs? _____ If so what? _____
Does student have any other allergies? (e.g. bee sting, dust, etc.) _____
Does student have _____ asthma _____ epilepsy _____ diabetes? (Yes or No answers)
Is student on any medications? _____ If so, what? _____
Does student wear contact lenses/glasses _____ Ever suffer a Concussion? _____

NAME OF PERSON(S) TO CONTACT IN CASE OF EMERGENCY-*****NOT IN YOUR HOUSEHOLD*****

#1 Name: _____ Relationship to student: _____
Daytime Ph.#: _____ Evening Ph. #: _____
#2 Name: _____ Relationship to student: _____
Daytime Ph.#: _____ Evening Ph.#: _____

This release form is completed and signed of my own free will for the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

(Print)Parent/Guardian Name: _____ (if 18 years old or +) _____

Signature (parent/Guardian/self if 18 or +) _____ date: _____

***** PLEASE COMPLETE FORM WITH A PEN ONLY, THANK YOU*****

STUDENT INFORMATION MAY BE USED FOR DISTRICT USE FOR YEARBOOK, PHOTOGRAPHS, SPORTS INFORMATION (SUCH AS PROGRAMS OR ARTICLES). (LOCAL):

Circle: YES or NO parent signature: _____