COMMUNITY UNIT SCHOOL DISTRICT 300

HIGH SCHOOL ATHLETIC EMERGENCY/CLEARANCE CARD (PLEASE PRINT LEGIBLY)

☐ **DCHS** ☐ **JHS** ☐ **HHS**

Sport		**Grade Level** ◯ 9 ◯ 10 ◯ 11 ◯ 12 (Circle one)	
Student Name	**ID#**	**School Year**	
Phone Number		**Date of Birth**	
Address			
Mother's Name		**Mother's Contact Numbers:**	
Father's Name		**Father's Contact Numbers:**	
Local Emergency Contact Name:		**Emergency Contact Address:**	
Emergency Phone Number			
Local Physician's Name		**Physician's Address:**	
Physician's Phone Number			

AUTHORIZATION FOR MEDICAL TREATMENT

If neither parent can be contacted, I authorize the school personnel to take such emergency action as may be deemed necessary.

I give my consent and permission to any supervising coach of any sport in which my child is or may be participating, the right on my behalf and in my stand, to arrange for a licensed and certified physician and/or trainers to render and provide immediate treatment to my child as to injuries that may be sustained by my child while participating in such sport, whether directly or indirectly, and whether sustained during practice or in active inter-scholastic competition, where such injuries consist of, but are not limited to sprains, strains, minor fractures, dislocations, lacerations, contusions, abrasions, and similar injuries, and all without necessity of any further or additional express authorization by me, other than for this authorization.

My above permission and consent also extends to the right of any supervising coach or school personnel to arrange for immediate medical treatment by a licensed or certified physician and/or trainer, and for them to apply such emergency techniques as may be necessary to my child where the same, in their judgment, is deemed appropriate by reason of any injury sustained by my child, and where the same, in their judgment, is deemed reasonably necessary to preserve the life or limb of my child.

_____ _____

(Name of child to whom the authorization extends) (Date)

_____

(Signature of parent/ guardian)

Date of last tetanus shot: _____ Medications: _____

Student wears contact lenses: Yes ◯ _____ No ◯ _____ ***(Parent/guardian must complete this box)***

Any known medical conditions/allergies: _____

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