FOX CHAPEL AREA SCHOOL DISTRICT DEPARTMENT OF ATHLETICS
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, understand and agree that others may assist or participate in providing medical care to my child. In order to be able to provide appropriate care to my child, medical information may need to be shared with caregivers other than the treating physician. This may include, but may not be limited to the team/school physician, resident or student physicians, school nurse, school athletic trainer, student athletic trainers, and licensed physical therapists.

In the space below, please provide the requested information about your son/daughter and yourself.

_____	_____	_____
Student's Name	Date of Birth	
_____	_____	_____
Home Address	City/State	Zip Code
_____	_____	_____
Parent/Guardian	Phone	Email

Required Signatures:

By signing below, I am permitting the treating physician or therapist to discuss any and all necessary information pertaining to my child's overall health and well being with those associated with the Fox Chapel Area Athletic Program. This may include, but is not limited to the team/school physician, school nurse, athletic trainer, coaches, and athletic director.

_____	_____
Parent/Guardian (signature)	Date