

Permission to Treat Form
Jefferson City Schools

Athlete's Name _____ Grade _____

E-mail: _____

Parent/Guardians' Name _____

Home Phone _____ Cell _____

Emergency Contact _____ Phone # _____

Family Physician _____ Phone # _____

Special Conditions _____

Medications Student is Allergic to _____

Other Allergies _____

I authorize employed designees of Jefferson City Schools to obtain medical attention for my child while he/she is participating in extra-curricular athletic activities. In addition, the local emergency facilities have my permission to treat him/her for any illness or injury that occurs while participating in an athletic event.

Parent/Guardian

Date

Insurance Info.

Name of Insurance Co. _____

Policy Number _____