

# Jefferson City Schools

575 Washington Street • Jefferson, Georgia 30549



Phone (706) 367-2881

Fax (706) 367-1884

## Permission to Treat Form

Please print clearly.

Athlete's Name \_\_\_\_\_ Grade \_\_\_\_\_

Athlete's Email \_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone \_\_\_\_\_

Parent/Guardian's Email Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Telephone \_\_\_\_\_

Family Physician \_\_\_\_\_ Telephone \_\_\_\_\_

Special Conditions \_\_\_\_\_

Medications Athlete 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 my child for any illness or injury that occurs while participating in an athletic event.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Name of Insured \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_ Customer Service Telephone \_\_\_\_\_