Please return this form, to your coach, on the first day of practice

RFHS Emergency Treatment Medical Consent Form

Student's name:____ Birthdate:____/_____/_____ Medicaid No:__________
(Please Print)

Permission is hereby granted to the attending physician to proceed with any minor surgical treatments, x-ray examination, and immunizations for the above named student. In the event of serious illness or injury or the need for major surgery, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, the treatment necessary for the best interest of the above named student may be given. Permission is also given for the school Nurse and/or other school representative to provide the needed emergency first aid treatment to the student prior to his/her admission to medical facilities.

Signature of Parent/Guardian:____ Date:_______________

Parents Home Phone:_________________ Fathers Work Phone:____________________ Mothers Work Phone:______________

Emergency Contact No: (other than parent):____

Family Physician's Name & Phone No:____

Does Your Child:
Have Medical Problems: If Yes, Please list____

Have Allergies: Please list____

Takes Routine Medications: Please list____

Comments:____

____