

Student Name: _____

Grade _____

Address: _____

Date of Birth _____

Student Cell Phone # _____

PARENT PERMISSION AND AUTHORIZATION FOR TREATMENT

If your son/daughter has any particular health problems, or allergies, please describe:

**** All areas of this form must be completed! ****

Date of last tetanus shot: _____

Please list the following information pertaining to medical insurance:

Name of Insurance Company: _____

Policy Number: _____

Name of Policyholder: _____

Names of family to contact in an emergency:

Parent/Guardian Name Home Phone Cell Phone Work Phone

Parent/Guardian Name Home Phone Cell Phone Work Phone

Please include a name and phone number of persons to contact should you not be at the above numbers:

Parent/Guardian Name Home Phone Cell Phone Work Phone

I give my consent for this student to represent Cassville High School on activity trips without holding Cassville R-IV Schools or trip sponsors responsible in case of accident or injury.

I give permission for accompanying sponsors to provide or cause to be provided any emergency medical attention as deemed necessary. I understand that I will be notified in the event of any emergency situation as quickly as possible.

This permission and authorization is valid for the period of **July 1, 2014, through August 31, 2015.**

Parent/ Guardian Signature Date

Mailing Address City State Zip Code