Illini West School District #307
600 Miller Street, Carthage, IL 62321
Phone: (217) 357-2136
Fax: (217) 357-3569
Zak Huston, Athletic Director

Exhibit – Authorization for Medical Treatment

To be submitted to the Superintendent. (please print)

_____	_____
Student	Sport/Activity
_____	_____
Parent/Guardian	Home Phone
_____	_____
Home Address	Cell Phone
_____	_____
Physician	Physician Phone

Medical Information: (*list allergies, medications, conditions and any known restrictions)*

Date of last Tetanus Shot: Date of Birth:

INSURANCE INFORMATION

THIS MUST BE FILLED OUT COMPLETELY IN ORDER FOR YOUR CHILD TO PARTICIPATE

Does your son/daughter have medical insurance?
If yes, list the name of the insurance company:
Insurance Policy Number:

RELEASE FOR TREATMENT

I hereby give permission to the attending physician or hospital to administer appropriate medical treatment in the event I cannot be reached.

_____

Parent Name (print) Signature of Parent/Guardian Date