

**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.

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Parent Name (print)                                      Signature of Parent/Guardian                                      Date