EMERGENCY MEDICAL PERMIT FORM

Student's Name: ____________________

I, being the parent or guardian of the above named student, agree to permit this student to engage in extracurricular activities at West Central Area High School. I give permission to authorized school representatives to act in my absence to authorize members of the medical profession to treat injuries incurred in activities sponsored by the school. I shall assume all medical payments.

Father's Name: ____________________

Father's Address: ____________________

Father's Phone #: ____________________

Mother's Name: ____________________

Mother's Address: ____________________

Mother's Phone #: ____________________

Insurance Company: ____________________

Insurance Phone #: ____________________

Emergency Contact Name: ____________________

Emergency Contact Phone #: ____________________

Doctor's Name: ____________________

Doctor's Phone #: ____________________

Dentist's Name: ____________________

Dentist Phone #: ____________________

Parents Signature: ____________________

This form will be on file in the office as well as a copy of it will be given to your son's or daughter's coaches in the sport seasons in which they participate.