



LAST NAME		FIRST NAME		STUDENT ID #	
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COLUMBUS NORTH HIGH SCHOOL
Medical Release to Treat

2015-16 Authority to Treat and Waiver

PLAYER'S FULL NAME: _____

ADDRESS: _____

CITY & ZIP: _____

TELEPHONE #: _____

Is there any medical information we should know about the participant?

Allergies: _____

Medications: _____

Known Medical Problems _____

Physician _____ Telephone# _____

Insurance _____ Policy# _____

IN CASE OF EMERGENCY PARENT CONTACT

Name _____

Telephone Numbers

Home _____

Work _____

Cell _____

IN CASE OF EMERGENCY, WHEN PARENTS CANNOT BE REACHED, PLEASE CONTACT:

Full Name _____

BEST Telephone# _____

Print Mother, Father or Guardian Name

Print Mother, Father or Guardian Name

(Signature)

(Signature)