P.H.S. Athletic Department

LIMITED CONSENT FOR EMERGENCY MEDICAL CARE

I, (We) _____ and _____
(name) (name)

of _____, Marshall County, Indiana do hereby state that
(city)

I am (we are) the parent (s) or legal guardian (s) of: _____
(name of student)

born _____ who resides with me (us) at _____
(street address)

I (We) authorize the appropriate Plymouth Community School Corporation Coach to consent to any necessary emergency medical care including examination, diagnosis, treatment, local anesthetic, and hospitalization as deemed appropriate by the coach and a physician licensed to practice medicine in the state of Indiana. This emergency medical form is good for the school years _____ thru _____.

Date _____ _____
(Parent's or guardian signature)

Witness _____ Witness _____

MEDICAL HISTORY:
Allergies, if any, including medication and foods:

Chronic or existing disease or medical problems:

List any medication taken routinely:

MEDICAL INSURANCE CARRIER:

_____
(identification No.-B.C.-Acc't No.)

Home Phone No. _____

_____
(Family Physician Name & No.)