

Quinlan ISD Athletics Parent Authorization Form

This form must be filled out completely by the parent or guardian and returned to the Quinlan ISD Athletic Office prior to participation in any athletic program.

Student Name _____ Date of Birth _____ Grade in 2010-2011 _____

Primary Address _____

Home Phone _____

Fathers' Name _____

Home Phone _____

Address (If Different) _____

Work Phone _____

Cell Phone _____

Please add me to the athletic department newsletter _____

E-Mail _____

Mothers' Name _____

Home Phone _____

Address (If Different) _____

Work Phone _____

E-Mail _____

Please add me to the athletic department newsletter _____

Cell Phone _____

Emergency Contact Information (to be used when parents cannot be reached)

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Primary Care Physician _____ Office Phone _____

Permission to notify physician if parents cannot be reached Yes _____ No _____

Permission to be treated for emergency care at hospital if parents cannot be reached Yes _____ No _____

Medical History (if none, please put N/A)

Known Allergies _____

Previous Medical Problems _____

Current Prescription Medication _____

As the parent or guardian of the named student athlete of Quinlan ISD, please identify the following over-the-counter medication that you give permission to be administered to said child at the discretion of the team physician or athletic trainer:

	Yes	No
Acetaminophen (Tylenol)	_____	_____
Benadryl	_____	_____
Cold/Cough Medicine	_____	_____
Ibuprofen (Advil)	_____	_____
Naproxen Sodium (Aleve)	_____	_____
Tums	_____	_____

***Form not valid if this section is not complete!**

*All prescription medications that may be required by a student during school hours must be supplied by the parent, brought to school in original container, and given to school nurse regardless of student's age.

Insurance Information (if none, please put N/A)

I have PPO Insurance Plan Yes No I have a HMO Insurance Plan Yes No

Primary Health Insurance Provider _____ ID# _____

Name of Insured _____ Insured's Employer _____

I the undersigned, do hereby authorize the officials of Quinlan ISD to contact the persons named on this form, and do authorize that this said student may receive acute care and treatment of all injuries sustained in athletic activity as determined by the Licensed Athletic Trainer practicing in the state of Texas under the supervision of the named physician or team physician.

_____ Date

_____ Signature of Parent or Guardian