

STUDENT NAME:			
BIRTHDATE			
PARENT/GUARDIAN NAME			
HOME ADDRESS OF PARENTS/GUARDIAN			
EMERGENCY CONTACT #			
PARENT/GUARDIAN EMPLOYER		PHONE #	
HEALTH INSURANCE COMPANY		GROUP #	
FAMILY PHYSICIAN		PHONE #	
CURRENT MEDICATION:			
DATE OF LAST DPT IMMUNIZATION:			
<p>ASTORIA SCHOOL DISTRICT 1C AUTHORIZATION FOR ANOTHER TO CONSENT TO TREATMENT OF CHILD:</p> <p>As a parent or legal guardian of the following student, _____, I hereby authorize the supervising athletic coach, school employee or his/her designee at the time of the accident to consent to any medical or surgical treatment of the above student which such person deems advisable if a parent or legal guardian cannot reasonably be located when the student is taken for treatment. The above authorization will be effective while participating in school activities.</p>			
PARENT/GUARDIAN SIGNATURE:			

Please circle the sport you are participating in:

BOY'S SOCCER	GIRL'S SOCCER	FOOTBALL	VOLLEYBALL	CROSS COUNTRY
BAND	GIRL'S BASKETBALL	BOY'S BASKETBALL	SWIMMING	WRESTLING
TRACK	SOFTBALL	BASEBALL	GIRL'S GOLF	BOY'S GOLF
DANCE	OHSET			

AHS OFFICE STAFF ONLY

CLEARED TO PARTICIPATE: _____