LYNDON INSTITUTE
MEDICAL INFORMATION AND PARENTAL PERMISSION FORM

Signature on this form indicates that the student athlete and parent (s) or guardian (s) agree to abide by the athletic policies of the Vermont Principals' Association and Lyndon Institute

ATHLETE'S NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PARENT/GUARDIAN'S NAME _____

PHONE: HOME _____ WORK _____

ATHLETE'S INFORMATION

DATE OF BIRTH _____/ _____/ _____

SOCIAL SECURITY # _____

SPORT(S): _____

BROKEN BONES DATE: _____

RECENT HEAD INJURY DATE: _____

PHYSICAL PROBLEMS OR RESTRICTIONS _____

_____

IS ATHLETE CURRENTLY ON ANY MEDICATIONS? _____ YES _____ NO

IF SO, WHAT ARE THEY? _____

ANY ALLERGIES? _____

DATE OF LAST TETANUS SHOT: _____/ _____/ _____

INSURANCE COMPANY _____

POLICY NUMBER _____

PERMISSION FOR TREATMENT

To the Parent or Guardian: In case of injury acquired during interscholastic competition, athletic practice, physical education, on school grounds, or during a school sponsored activity, I hereby consent to have the above named student examined and, if required, to be treated by a physician or hospital. I am of the understanding that in case of injury, Lyndon Institute will make every effort to contact me prior to taking the student to a physician or hospital. In the event that I cannot be notified, Lyndon Institute and its representative has my permission to take appropriate steps to insure the safety and well being of my child.

I, the parent/guardian of _____, give Lyndon Institute and authorized personnel permission to sign for treatment in case of accident or injury.

Liability Release:

I am aware that playing or practicing in any sport can be dangerous in nature involving MANY RISKS OR INJURY - major and minor. Because of the dangers of participating in sports, I recognize the importance of following coach's instruction regarding playing techniques, training and other team rules and agree to obey such instructions. I/we understand that Lyndon Institute is not liable for any injury that may occur.

SIGNATURE BLOCK

*** Student** _____ *** Parent/Guardian** _____

DATE: _____

PHYSICIAN'S STATEMENT

This is to certify that _____ was examined by me is/is not physically able to compete in athletics.

SIGNED _____ **DATE** _____

White - Team Packet	Yellow - Trainer	Pink - Athletic Director

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