# HOLLAND PUBLIC SCHOOLS

**600 Van Raalte Avenue**
**Holland, MI 49423**
**Ph: (616) 494-2250**
**Fax: (616) 393-7556**

## EMERGENCY INFORMATION & PERMISSION TO TREAT

**Name:**_____ **Grade:**_____

**Parent/Guardian(s) Name(s):**_____

**Address:**_____

**Home Ph:**_____ **Daytime Ph:**_____ **Evening Ph:**_____

## EMERGENCY CONTACTS:

**Name:**_____ **Relationship:**_____ **Ph:**_____

**Name:**_____ **Relationship:**_____ **Ph:**_____

**Family Physician:** _____ **Ph:**_____

## INSURANCE INFORMATION:

**Family Insurance Company/Carrier:**_____

**Contract/Group Number:**_____ **Ph:**_____

## PLEASE DETAIL ANY SPECIAL MEDICAL INFORMATION BELOW

(allergies, bee sting allergies, known drug reactions, current prescribed medications, asthma, seizure disorders, heart condition or disease, etc.)

_____

_____

_____

## PERMISSION TO TREAT:

I,_____, hereby give permission for my son/daughter, _____ to undergo medical treatment for any injury or illness he/she may sustain or acquire while engaged in athletics with Holland Public Schools. I understand the medical personnel of Holland Public Schools, including athletic trainers and team physicians will perform only those procedures within their training, credentialing, and scope of professional practice to prevent, care for, and rehabilitate athletic injuries. In the event more serious medical procedures are required and I cannot be contacted for my consent, I authorize any licensed medical practitioner to perform such procedures medically necessary to alleviate the problem.

_____ _____

Parent/Guardian Signature Date