ABRAHAM JOSHUA SCHOOL MEDICAL CERTIFICATE FOR INTERSCHOLASTIC COMPETITION

*No student may participate on a team until the physical education/athletic department has received this completed form.

Date

I hereby acknowledge that I may not be available to provide consent for medical treatment and dispensing of any medication in the event that my child becomes sick or is injured during any athletic participation authorized below. In the event that I am not able to give such consent, it is my desire to have the best available medical treatment for my child. I here authorize representatives of the Abraham Joshua Heschel School to act on my behalf with respect to any required medical treatment decisions and consents, until such time as I am able to provide these.

Any qualified medical personnel are hereby notified that this authorization is currently in effect and such personnel are directed to act upon such authorization without delay. I understand that every effort will be made to contact parents, the child's physician and/or the emergency number given by me on this form.

Name of Student: Team:

Grade: Birth Date: Home Phone:
Parent/Guardian (1) Name:

Parent (1) Cell:

Parent (1) Work Phone

Parent/Guardian (2) Name:

Parent (2) Cell:

Parent (2) Work Phone

Person to notify if unable to reach parents:

Name Phone

Physician Phone

*Health Insurance Name:

*Health Insurance ID #:

Hospital of choice (name & address):

Signature of parent or guardian: