

**WINNACUNNET ATHLETIC DEPARTMENT**  
**Emergency Treatment Card and Permission for Medical Treatment**

In the event of an emergency requiring medical attention, I hereby authorize medical treatment for my son/daughter in the event I cannot be reached and treatment is necessary due to injury sustained while my son/daughter is participating in the athletic program of Winnacunnet High School. Such medical treatment shall be given by a licensed physician in the field of medicine at my expense. In the interim, my child may be attended to by a licensed, certified athletic trainer.

Student athlete name \_\_\_\_\_

I expect every effort will be made to contact me in order to receive my specific authorization before any further treatment or hospitalization is undertaken.

Parents name (Mother) \_\_\_\_\_ Work # \_\_\_\_\_ Home # \_\_\_\_\_

(Father) \_\_\_\_\_ Work # \_\_\_\_\_ Home # \_\_\_\_\_

If unable to contact the above person(s), please contact:

Name(s) \_\_\_\_\_ Work # \_\_\_\_\_ Home # \_\_\_\_\_

\_\_\_\_\_ Work # \_\_\_\_\_ Home # \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone # \_\_\_\_\_

Family Dentist \_\_\_\_\_ Phone # \_\_\_\_\_

Any allergies or specific medical problems to be aware of: \_\_\_\_\_

\_\_\_\_\_

**Parent signature:** \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_