

Spartanburg School District Six Sports Medicine

Medical Release Form

I, _____,
(parent's name)

hereby authorize and request medical care be administered to _____,
(athlete's name)

Age _____, my son/daughter, while participating in the interscholastic athletic program representing Spartanburg School District Six, by the student health service and such hospital and/or any other medical doctor or medical institution which might render services in event of injury, illness, or accident. I further request that records of such treatment be released to the Spartanburg School District Six Athletic Trainer, Head Coach of his/her sport, or its insurance carrier, in order that they will be better informed of his/her medical condition and capabilities while participating in athletic competition at Spartanburg School District Six.

Date: _____ Signature of Parent/Guardian _____

Home Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Alternate Emergency Contact: Name: _____

Student's Date of Birth: _____

INSURANCE INFORMATION

Name of Company: _____

Address of Company: _____

Phone Number of Company: _____ Policy Number: _____

Is this an HMO/PPO? Yes _____ No _____

If yes, name of personal physician: _____ Phone: _____

Medications Used: _____

Allergies: _____

Preference of Hospitals: _____

A photocopy or facsimile of this document shall be considered the same as the original document.