

Sport _____

Sport _____

Parent Permit to Travel/Emergency Treatment Card

Student's name: _____ Date of birth: ____/____/____ Sex: male female

Student's social security: _____ School: _____ Grade _____

Address: _____ Home phone: _____

Father's name: _____ Employer: _____

Father's Cell/Pager _____ Work Phone _____

Mother's name: _____ Employer: _____

Mother's Cell/Pager _____ Work Phone _____

Family physician: _____ Office number: _____

Emergency contact in case parent/guardian *cannot* be reached

Name: _____ Relationship: _____

Phone: (home) _____ (work) _____

I hereby give my consent for the above student to compete in University Interscholastic League, or school sponsored activities approved events, and travel with coach, sponsor or representative of the school on any trips.

Neither the University Interscholastic League nor Conroe ISD assumes any responsibility in case an accident occurs.

If, in the judgement of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize and consent to such care and treatment as may be given to said student by any physician, athletic trainer, nurse, hospital, or school representative; and I do hereby agree to indemnify and save harmless the school and any school representative from any claim by any person whomsoever on account of such care and treatment of said student.

CISD 35

Parent/Guardian signature _____

Date _____

Insurance Information

Medical History - Does your child have a previous history of:

- | | Yes | No |
|--|--------------------------|--------------------------|
| Bone/joint injury or disease?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Neck injury?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Being unconscious / knocked out?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Seizures / convulsion? | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent headaches?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding / blood disorders?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Heat illness..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergies (seasonal, insects)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergies (medications)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> |
| Viral infection (mono)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Eye/vision problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| Missing / non-functioning limbs | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Emotional disturbance?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Take medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| Had surgery in the past year?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Currently under physicians care? | <input type="checkbox"/> | <input type="checkbox"/> |
| Wearing contacts / glasses?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Date of recent immunizations: | | |

Tetanus: _____

Hepatitis: _____

Explain all "yes" answers. _____

Sponsor Copy of Travel Card

To be completed by parents/guardians

Insurance Information

My child is covered under the insurance policy of (check one):

father mother none

Insured's name _____

Insurance company _____

Insurance company address _____

Insurance company phone number _____

Group # _____

Policy # _____