



Jefferson City Schools
575 Washington Street – Jefferson, Georgia 30549

Phone (706) 367-2881
Fax (706) 367-1884

Permission to Treat Form

Please print clearly. Grade _____

Athlete's Name _____ Birthdate _____

Athlete's Email _____

Parent/Guardian's Name _____

Parent/Guardian's Email _____

Parent/Guardian's Number _____

Home Address _____

City _____ Zip _____

Special Conditions _____

Medications Athlete is Allergic to _____

Other Allergies _____

Emergency Contact _____ Telephone _____

Family Physician _____ Telephone _____

Name of Insured _____

Name of Insurance Company _____

Policy Number _____

Customer Service Number _____

I authorize employed designees of Jefferson City Schools to obtain medical attention for my child while he/she is participating in extra-curricular athletic activities. In addition, the local emergency facilities have my permission to treat my child for any illness or injury that occurs while participating in an athletic event.

Signature of Parent/Guardian _____ Date _____