Rochester Area School District

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Elementary School Principal
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Director of Maintenance and Facilities
Mr. Nathan Leeman
Director of Student Services
Mr. Rodney Bobin
Director of Technology
540 Reno Street, Rochester, PA 15074
Phone 724-775-7500 Fax 724-775-4077

Dear Parent/Guardian,

In times of emergency or serious injury, coaches are faced with many decisions, which can increase or decrease the opportunity of providing prompt medical care for an injured athlete.

One of our most important functions is to get injured athletes safely to proper medical facilities, which can provide appropriate care. However, in most high school situations, once the athlete is admitted to the emergency room, treatment cannot be initiated without the consent of a parent or guardian.

In an effort to alleviate this problem, the athletic staff has developed Permission for Medical Treatment Form. Before an athlete is allowed to participate in our athletic program, he or she must return this form with the required signatures and information. In the event that an athlete becomes injured and requires medical care, this form will be sent with the athlete to the nearest medical facility.

Please note that this for will be used ONLY when all efforts to notify you have failed. It DOES NOT replace your specific authorization if you are available. This form will be used at any local medical facility where our athletes receive treatment.

If you have any questions concerning this form, please feel free to contact the coach, athletic director or building principal.

Sincerely,

Brad Verrico
Athletic Director

Michael S. Damon
MS/HS Principal

/ba 05/15

Rochester Area School District

HISTORY FORM

NAME_____AGE_____GRADE
Last First Middle

ADDRESS_____BIRTHDATE_____
PARENT/GUARDIAN_____CELL PHONE_____
ADDRESS_____

If parent/guardian cannot be reach, In case of emergency, contact:

_____
(name) (relationship) (phone)

_____
(name) (relationship) (phone)

IS YOUR CHILD:

- Presently under a doctor's care? ____If so, please explain_____
  _____
- Presently taking any medications? ___If so, please list_____
  _____
- Allergic to any type(s) of medication? ___If so, please list_____
  _____
- ~~Allergic to any type(s) of insect bites/stings? ____if so please list~~_____
  _____

Does your child wear (please circle)
GLASSES CONTACTS NEITHER
Has your child ever had a concussion or any type of head injury? ___if so, please explain_____

_____

Please list any other facts about your child's medical history that medical personnel and coaches need to be aware of_____

_____

_____ _____
Signature of Parent/Guardian Date

*THIS FORM IS TO BE MAINTAINED BY THE HEAD COACH UNTIL THE END OF THE SCHOOL YEAR (JUNE 30), THEN DESTROYED

Rochester Area School District ... where great things are happening!