Vernon Verona Sherrill Central Schools Athletic Department
5725 State Route 31, Verona, NY 13478 • (315) 829-7457

Randy Thomas, *Athletic Director*

MEDICAL CONSENT FORM

Name (Last, First, Initial):				Child residing with:
Home Address:				❑ mother and father
Phone Number:				❑ mother
Date of Birth:		Age:		❑ father
Name of Parent/Guardian:				❑ guardian

Emergency Contact Name:	
Address:	
Phone Number:	

Allergies:	❑ food ❑ drugs ❑ hay fever ❑ insect stings ❑ asthma ❑ ivy, oak, etc.
Date of last Tetanus Booster:	
Other diseases/details of above:	

Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examinations, and immunizations for the above-named athlete. In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, the treatment necessary for the best interest of the above-named athlete may be given.

Parent/Guardian Signature: _____ Date: _____

Family Physician: _____ Phone: _____