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| --- | --- | --- |
| Name | | School Year  **2019-2020** |
| Home Phone Number | | Date of Birth |
| Address | | |
| City, State, Zip | | |
| Parent/Guardian Name | Parent/Guardian Phone Number | |
| Emergency Contact | Emergency Contact Phone Number | |
| Family Physician | Physician’s Phone Number | |
| Name of Person Responsible for Your Medical Bills (Guarantor) | Do you have any known allergies:  If yes please list: | |
| Guarantor’s Employer |
| Insurance Company | Do you have a history of allergies, heart condition, diabetes, asthma, epilepsy, rheumatic fever other existing medical conditions?  If yes, please explain. | |
| Insurance Plan Number |
| Insurance Group Number |
| Insured ID Number |
| Are you taking any medications? Are you currently under medical treatment? If yes, please explain. | Do you have any physical restrictions? If yes, please explain. | |

**Medical Authorization**

In the event the parent/guardian cannot be contacted, we authorize the Rockdale ISD representative:

1. To represent us before any medical institution where it may be necessary to send our son/daughter while he/she is under its care;
2. To give, in our name, the necessary authorization for surgery or medical treatment in case of emergency, when medical authorities deem it indispensable;
3. To represent us while he/she is under supervision of school activities

This medical form and authorization can be used by the sponsor of a CTSO for multiple events over the course of the designated school year.

Signature of Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_