Medical Consent Form – Combine Academy Athletics

I (Parent's Name)_____ authorize the administration of the below medications at **Combine Academy** to (Student's Name)_____.

Medication(s):

Medication	Dosage	Frequency	Date to Begin	Date to End

STUDENT'S HEALTH INFORMATION

Allergies: _____

Pre-Existing conditions: _____

PARENT'S CONTACT INFORMATION

Name: _____

Phone number: _____

PHYSICIAN'S CONTACT INFORMATION

Name: _____

Phone number: _____

Address: _____

Parent Signature: _____

Date: _____