

**DETROIT COUNTRY DAY SCHOOL  
PERMISSION FOR STUDENT TO TRAVEL TO AN OFF CAMPUS EVENT AND  
REQUEST FOR MEDICAL INFORMATION**

Sport: \_\_\_\_\_ Season Dates: \_\_\_\_\_

Transportation: DCDS School Bus Faculty Chaperones:

Name of Student \_\_\_\_\_ Grade: \_\_\_\_\_ Age: \_\_\_\_\_ Birth date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_

Insurance Company \_\_\_\_\_ Insurance Number : \_\_\_\_\_

Please provide the name and number(s) of Parent/Legal Guardian who can be reached in case of an emergency:

Name of Legal Guardian to be contacted: \_\_\_\_\_

Cell #: (\_\_\_\_) \_\_\_\_\_

Work #: (\_\_\_\_) \_\_\_\_\_

Other #: (\_\_\_\_) \_\_\_\_\_

Second Contact Person: \_\_\_\_\_

Cell #: (\_\_\_\_) \_\_\_\_\_

Work #: (\_\_\_\_) \_\_\_\_\_

Other #: (\_\_\_\_) \_\_\_\_\_

Please print the name of the athlete below:

\_\_\_\_\_ has my permission to travel with the upper school \_\_\_\_\_ team to scheduled away games. Should the need for medical treatment arise, coaches/trainers of Detroit Country Day School have my permission to seek care at an emergency center at my expense.

PRINT THE NAME OF THE LEGAL GUARDIAN: \_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(OVER)

Please circle YES or NO and provide additional details where requested. All information will remain confidential.

**MEDICAL/HEALTH CONCERNS:**

- |   |    |     |
|---|----|-----|
| 1. Do you have a medication allergy (penicillin, sulfa, aspirin)? (LIST)  | NO | YES |
| _____   |    |     |
| 2. Do you have any other allergies (food, insect, etc.)? (LIST)   | NO | YES |
| _____   |    |     |
| 3. Do you take any prescription medications on a regular basis? (List and give reasons)                                 | NO | YES |
| _____   |    |     |
| _____   |    |     |
| 4. Have you ever been treated for diabetes? (List medications)  | NO | YES |
| _____   |    |     |
| 5. Has a doctor ever told you that you have asthma? (List treatment)  | NO | YES |
| _____   |    |     |
| 6. Have you ever had a seizure or been told you have epilepsy? (Explain)  | NO | YES |
| _____   |    |     |
| 7. Do you have or have you ever had high blood pressure? (List medication)  | NO | YES |
| _____   |    |     |
| 8. Have you ever had surgery? (List type and reason)  | NO | YES |
| _____   |    |     |
| 9. Have you ever stayed overnight in a hospital? (List reason and date)   | NO | YES |
| _____   |    |     |
| 10. Have you ever injured your leg, arm, shoulder, or back? (List injury & date)  | NO | YES |
| _____   |    |     |
| _____   |    |     |
| 11. Have you ever had a head or neck injury? (Include concussions and date)   | NO | YES |
| _____   |    |     |
| 12. Do you have any other conditions we should be aware relating to the welfare of the athlete? Specify & give details. | NO | YES |
| _____   |    |     |
| _____   |    |     |

**THE QUESTIONS ON BOTH SIDES OF THIS FORM HAVE BEEN ANSWERED COMPLETELY AND TRUTHFULLY TO THE BEST OF MY KNOWLEDGE.**

Signature of athlete \_\_\_\_\_ Date \_\_\_\_\_

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