SPORT:				
	or Medical Treatment	Health History	YES	NO
	n emergency requiring medical attention,	Kidney Injuries:		
	ermission to a physician or other hospital	Heart Condition/Disease:		
	nated by the Sun Prairie High School	Diabetes:		
	o attend to my son/daughter:	Asthma:		
J	·	Mile il a como dia se el como como		
		While competing, do you wear: Glasses		
Date		Contacts		
	ffort will be made to contact me in order	Contacts		-
or hospitalization	pecific authorization before any treatment	Allergy to any medication:		
oi nospitalizatioi	i is undertaken.	7 morgy to any modication.		
		Please state:		
Home Phone	Signature of Parent of Guardian			
Rusiness Phone	Home Address of Athlete	Date of last Tetanus Shot:		
Dubiness i none	Home Address of Adhete			
F!!- Bl!-!-	Displaying Displaying	PLEASE COMPLET	E REVERSE S	SIDE
Family Physician	Physician Phone			
SPORT-				
J. J.K.I.		Health History	YES	NO
Permission fo	or Medical Treatment			
	n emergency requiring medical attention,	Kidney Injuries:		
	ermission to a physician or other hospital	Heart Condition/Disease:		
personnel design	nated by the Sun Prairie High School	Diabetes:		
Coaching Staff t	o attend to my son/daughter:	Asthma:		
		While competing, do you wear:		
Date	Name of Athlete	Glasses		
	ffort will be made to contact me in order	Contacts		
	pecific authorization before any treatment	Comado		
or hospitalization		Allergy to any medication:		
ooopaao.				
		Please state:		
Home Phone	Signature of Parent of Guardian			
		Date of last Totanus Chat		
Business Phone	Home Address of Athlete	Date of last Tetanus Shot:		
		PLEASE COMPLET	E REVERSE S	SIDE
Family Physician	Physician Phone			
SPORT:		Health History	YES	NO
Permission fo	or Medical Treatment			
	n emergency requiring medical attention,	Kidney Injuries:		
	ermission to a physician or other hospital	Heart Condition/Disease:		
personnel design	nated by the Sun Prairie High School	Diabetes:		
Coaching Staff to	o attend to my son/daughter:	Asthma:		
		While competing, do you wear:		
Date	Name of Athlete	Glasses		
	ffort will be made to contact me in order	Contacts		
	pecific authorization before any treatment	55350		
or hospitalization		Allergy to any medication:		
Sprisiizatioi			<u></u>	
		Please state:		
Home Phone	Signature of Parent of Guardian			
		Date of last Tatania Chat		
Business Phone	Home Address of Athlete	Date of last Tetanus Shot:		
		PLEASE COMPLET	E REVERSE S	SIDE
Family Physician	Physician Phone			

INJURY AND REHABILITATION RECORD

Date of Injury	Nature of Injury	How did Injury Happen	Sport	Date Treated	How Treated	Hospital/ Doctor	Date: Hospital/ Doctor	Rehabilitation	Trainer

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Date of Injury	Nature of Injury	How did Injury Happen	Sport	Date Treated	How Treated	Hospital/ Doctor	Date: Hospital/ Doctor	Rehabilitation	Trainer

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Date of Injury	Nature of Injury	How did Injury Happen	Sport	Date Treated	How Treated	Hospital/ Doctor	Date: Hospital/ Doctor	Rehabilitation	Trainer