Unified School District 423
Permission for Treatment
Dr. Matthew Vermillion, DPT
2023-2024

Moundridge USD 423, 526 E Cole Street, Moundridge, KS 67107
FAX: 620-345-8617

The undersigned is a natural parent, guardian or other person qualified and authorized to execute the following Permission for Treatment and herby give or refuse my permission and consent as specified below for the treatment of the minor child identified below in my absence for any serious on non-serious injuries such child may suffer during athletic practice or competition conducted under the supervision of the employees and agents of the USD 423 (the "District").

With respect to any injury or condition that, in the judgment of District personnel, requires the attention of a physician, District personnel will attempt to contact the physician identified below. In the event of serious injury, the child will be transported to the nearest emergency medical facility for treatment.

I also give my permission and consent for the use of ultrasound, electric stimulation, ice, heat or other forms on non-invasive treatment to relieve the symptoms for sprains, strains, muscle pulls, contusions and other minor injuries and for the administration of aerosol, oral or injectable medications commonly recognized and routinely available and intended for the emergency treatment of allergic reactions. Except in the event of an emergency, District personnel will attempt to contact the parent or guardian of such minor child prior to providing such treatment.

No charges will be made for treatment provided by District personnel before and during competition or practice on the property of the District unless the minor child is under the care of a physician and such treatment is provided or administered under the supervision or at the direction of such physician.

I have read, understand and have voluntarily signed this Permission for Treatment.

I DO_____/ DO NOT_____ give my permission for treatment as provided above (please check one).

Student's Name (Please Print):_____

Name of Parent/Guardian (Please Print):_____

Personal or Family Physician:

(Name)_____

(Address)_____

(Telephone)_____

Signature of Parent/Guardian_____Date_____