LAKESIDE HIGH SCHOOL
3801 Briarcliff Rd., N.E.
Atlanta, GA 30345

TO: Medical Doctor
Medical Facility Director

I, ____,
(Printed Name of Parent or Guardian)

Parent or Guardian of __________________________,
(Name of child/ward)

do herein freely give my consent to the Lakeside Swim/dive coaches/chaperones in charge of my child/ward, who is taking part in these DeKalb County-approved swim/dive meets to bring my child/ward to your medical facility for the purpose of examination, treatment, and/or surgical procedure(s), which you are authorized to perform pursuant to current policies and regulations.
I do furthermore herein freely given my consent for you to perform such examination, treatment, or surgical procedure(s) as you may deem necessary to treat injuries received in connection with and/or illness arising during these DeKalb County-approved swim/dive meets.

My child/ward has the following medical problems and /or allergies:

____

Our family doctor is___________________________________, and is located at the following

address ____, phone_______________

I understand and agree that I will be responsible for all medical treatment cost. My child/ward is covered by a group protector accident-sickness insurance, school insurance, or medical insurance coverage provided by:____.

Signed:__________________________________ Date______________________
(Parent/Guardian signature)

Emergency contacts:____

____
(Name and number of 2 people)