EMERGENCY INFORMATION

Please Print
Name:_____ DOB:_____ Age:_____
Grade:____Sports(s):_____ Home Phone:_____
Parent (Guardian)Name: _____
Address: _____
Daytime Phone # of Parent/Guardian: Father: _____
Mother: _____

In an EMERGENCY, if parents CANNOT be contacted, please notify:
Name:_____Relationship:_____
Home Phone:_____Daytime Phone:_____
Address:_____
Medical Insurance Carrier:_____ Policy #_____
Address:_____Phone#_____
Family Physician:_____ MD or DO (circle one)
Address_____ Phone#_____
_____

Athlete's Allergies_____
Student's Health Condition(s) of which Physician should be aware:
_____
_____
Student's Perscription Medications:_____
Student's Immunizations (e.g. tetanus, measles, mumps, rubella, hepatitis A, B, influenza, poliomyelitis, pneumococcal, meningococcal, varicella): up-to date:_____
Not up-to-date : Please specify:_____

The athletic trainer, team physician, and coach may apply first aid treatment
Until the family doctor and parent can be contacted YES____ NO____

We give our consent for the athletic trainer, team physician, and coaches to use
Their judgment in securing medical aid and ambulance service in case parents/
Guardians cannot be reached. YES____ NO____

We give our consent for emergency room hospital personnel to use their judgment in beginning emergency treatment in case parents/guardians cannot be reached. YES____NO____

THIS FORM MUST BE AVAILABLE AT ALL PRACTICES AND GAMES