

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: _____ MC or DO (circle one)
Address _____ Phone# _____

Athlete's Allergies _____
Student's Health Condition(S) of which Physician should be aware: _____

Student's Prescription Medications: _____
Student 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