STUDENT ATHLETIC EMERGENCY INFORMATION CARD

NAME _____ SPORT _____ DATE _____

ADDRESS _____PHONE NO. _____

MOTHER'S NAME _____WORK PHONE NO. _____

CELL PHONE NO. _____

FATHER'S NAME _____ WORK PHONE NO. _____

CELL PHONE NO._____

Please list two (2) emergency contacts (relatives or neighbors):

1. NAME _____ PHONE NO. _____

2. NAME _____ PHONE NO. _____

FAMILY DOCTOR_____ PHONE NO. _____

Medication taken regularly: _____

Allergies: _____

Does this athlete have Asthma? _____ Inhaler type _____

Previous injuries or illness that could be of concern if a medical emergency arises: _____

_____

List all injuries that resulted in loss of playing time or practice: _____

_____

HEALTH INSURANCE CO. NAME _____ GROUP NO. _____

CONTRACT NO. _____ SERVICE CODE _____

In the event of a serious accident or illness, I request that a representative of the School System contact me. If I cannot be reached, I request that contact be made with our family doctor and his instructions be followed in the treatment of my child. If the emergency is such that immediate medical care is necessary, I authorize the School System to transport my child to a hospital for emergency care. The hospital, their agents, or licensed physician, may administer such emergency medical treatment as they deem necessary under the circumstance.

SIGNATURE OF PARENT/GUARDIAN _____DATE _____

I <u>do not</u> give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take <u>no action or to:</u>

_____

_____

SIGNATURE OF PARENT/GUARDIAN _____DATE _____