ATHLETE EMERGENCY INFORMATION

PARENTS/GUARDIANS: PLEASE FILL IN ALL LINES COMPLETELY

PRINT STUDENT'S NAME:_____ **D.O.B.**_____**GRADE:**____

SPORT: _____

ADDRESS: _____ CITY: _____ ST./ZIP: _____

PHONE NUMBERS: HOME #: _____

FATHER: _____ WORK #: _____

CELL #: _____

MOTHER: _____ WORK #: _____

CELL #: _____

EMERGENCY CONTACT NAME: _____ WORK #: _____

CELL #: _____

PHYSICIAN: _____ PHONE #: _____

DENTIST: _____ PHONE #: _____

LIST ANY KNOWN ALLERGIES: _____

Please provide any other health information which would help us meet the needs of your child. Include such conditions as: serious allergies, asthma, diabetes, ear & eye problems, heart conditions, seizure disorders, orthopedic conditions; any specialized health care needs; dietary restrictions.: _____

_____

DATE OF LAST DIPHTHERIA/TETANUS IMMUNIZATION: _____

LAST PHYSICAL EXAM DATE: _____

INSURANCE COMPANY NAME: _____ GROUP/PLAN #: _____

IN CASE OF EMERGENCY: I request my child be taken to _____**hospital. If the school or hospital is unable to contact me, I hereby authorize the school and/ or physician to treat my child as they deem necessary.**

_____ _____

SIGNATURE OF PARENT/GUARDIAN **DATE**