

EMERGENCY INFORMATION

Name _____ Grade _____

Sport _____ Age _____

Address _____ Home Phone _____

Name of Parent/Guardian:

Mother _____ Cell Phone _____

Work Phone _____ Hours Can Be Contacted _____

Father _____ Cell Phone _____

Work Phone _____ Hours Can Be Contacted _____

Please Check All That Apply:

Conditions:

Asthma Epilepsy Diabetes Kidney Failure Heart Condition

Requires Inhaler Athlete has doctor's order to self-administer: YES

Allergies:

Bee Sting Pollen Medication Other _____

Requires EpiPen Athlete has doctor's order to self-administer: YES

If Allergic to Medication, Please State the Medication: _____

Are you taking medication at the present time? Yes No

If yes, please state the medication and reason for use:

In An Emergency When the Parent/Guardian Cannot be Contacted:

Notify: _____ Phone: _____

Student's Physician: _____ Phone: _____

Preferred Hospital _____

The team physician, trainer and coach may apply first aid treatment until medical aid and/or ambulance service arrives: YES NO

We give our consent for coaches, trainers, and team physicians to use their own judgment in securing medical aid and ambulance service in the event of an emergency: YES NO

Date

Parent/Guardian Signature

