Emergency Contact, Medical Information & Medical Treatment Consent

To Be Completed by Parent or Guardian (Please Print)

Student's Name: _____ Grade: _____ Date of Birth: _____/_____/_____

Student's Home Phone: _____

Sports: Fall: _____ Winter: _____ Spring: _____

Insurance Information:

Insurance Company: _____ Group: _____ Plan/Contract: _____

Primary Care Physician: _____ Office Phone: _____

EMERGENCY CONTACT:

1. Name: _____ Relationship: _____

   Home: _____ Cell: _____ Work: _____

   Lives with student: YES NO
   Authorized for medical decisions: YES NO

2. Name: _____ Relationship: _____

   Home: _____ Cell: _____ Work: _____

   Lives with student: YES NO
   Authorized for medical decisions: YES NO

Medical Information:

Current over the counter or prescription medications: _____

_____

Allergies: _____

Medical Conditions: _____

_____

Does athlete carry emergency allergy medication (Epi-Pen, insect sting kit, etc.): YES NO
Does athlete carry an asthma inhaler: YES NO

MEDICAL TREATMENT CONSENT:

I, _____ , the parent or guardian of _____ recognize that as a result of athletic participation, medical treatment on an emergency basis may be necessary, and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then-existing circumstances and to assume the expenses of such care.

_____ _____

Signature of Parent or Guardian **Date**