Athletic Program Student Emergency Form

_____ _____ _____

Student Name Date of Birth Grade

_____ _____

Street Address City –State-Zip

Parent/Guardian Business Address and Contact Information

_____

Mother's Name

_____ _____

Business Address Business Phone

_____ _____

E-Mail Address Cell Phone

_____

Father's Name

_____ _____

Business Address Business Phone

_____ _____

E-Mail Address Cell Phone

Insurance Information

Insurance _____

Group # _____ ID # _____

Other important insurance information: _____

_____

_____

over

Medical Emergency and Physician Information

In case of emergency, if my child is perceived to be in need of professional medical attention for personal safety, I give permission for my child to be transported to the nearest hospital.

Parent Signature _____ Date _____

I wish the following doctor(s) to be notified:

_____ _____

Doctor Name Contact Information

Other Emergency or Physician Information:

_____

_____

_____

Special Instructions:

Any allergies? Other chronic illness? _____

_____

_____

Has your child experienced a concussion? _____ If yes, please explain when and briefly give circumstances: _____

_____

_____

Any other important or helpful information about your child that you would like to share with our Athletic Director and Coaching Staff:

_____

_____

_____

_____