



MEDICAL EMERGENCY INFORMATION

Student Name: _____ Date: _____

Student's/Family Physician: _____ Phone # _____

Health Insurance Policyholder's Name: _____

Policy # _____ *(Please submit copy of front and back of the insurance card)*

Emergency Contact 1 _____ Relationship to Student: _____

Phone number Home # _____ Cell # _____

Emergency Contact 2 _____ Relationship to Student: _____

Phone number Home # _____ Cell # _____

Does the student receive medication? Yes No

If yes, please give details: _____

Does the athlete have any allergies to food/medicine/other? Yes No

If yes, please explain: _____

Do we have permission to contact the doctor in an emergency? Yes No

Do we have permission to take your child to a hospital emergency room? Yes No

MEDICAL and TRANSPORTATION RELEASE

To Whom It May Concern:

I here by give my consent to any hospital and/or doctor to administer emergency treatment to myself/my child in the event of an emergency, provided such treatment is imperative. I also give my consent for myself/my child to be transported by ambulance if the situation warrants.

Parent Signature _____

Print Name _____ Date _____