**ATHLETIC**

**EMERGENCY INFORMATION FORM**

Student's Name (Last Name first):

Address (Street/City/Zip): Cell phone:

PARENT/GUARDIAN

Primary Parent/Guardian Email:

Primary Parent/Guardian Name: Home Phone:

Primary Parent/Guardian Address: Cell Phone:

 Work Phone:

Parent/Guardian Name: Home Phone:

Parent/Guardian Address: Cell Phone:

 Work Phone:

**EMERGENCY CONTACT INFORMATION**

List two names of emergency contacts who will assume temporary care of your child if you cannot be reached.

1. Name: Telephone:

2. Name: Telephone:

MEDICAL INFORMATION

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I nearby authorize the school to call the physician indicated below and to follow his/her instructions. If it is impossible to contact this physician, the school may make whatever arrangements seem necessary to provide care and treatment

Does your child have any of the conditions listed below?

Any known allergies? Yes \_\_\_\_ No \_\_\_ If so, type of allergy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma? Yes \_\_\_\_ No \_\_\_ Heart Disease? Yes\_\_\_\_ No\_\_\_\_

Convulsive Disease? Yes \_\_\_\_ No\_\_\_\_ Other chronic illness? Yes\_\_\_\_ No\_\_\_\_

Diabetes? Yes\_\_\_\_ No\_\_\_\_

Doctor’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dentist’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian with whom student resides:

Signature:

Date: