

EMERGENCY CONTACT INFORMATION FORM

\* PLEASE PRINT ALL INFORMATION

Player Name: \_\_\_\_\_

Age: \_\_\_\_\_

Sport: \_\_\_\_\_

Parent(s) Name: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Secondary contact person: \_\_\_\_\_ #: \_\_\_\_\_

Doctor name: \_\_\_\_\_ #: \_\_\_\_\_

Unless specified differently, all seriously injured athletes will be transported by ambulance to St. Vincent's Hospital.

Other Hospital Preference: \_\_\_\_\_

Insured: Yes \_\_\_\_: No \_\_\_\_:

Parent Signature: \_\_\_\_\_