Athlete's Emergency Information

Sport(s): _____ Birthdate: _____

Name: _____ Sex: M F Age: _____ Grade: _____

Address: _____ City: _____ Zip: _____

Parent's Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact (Other than parents) Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Insurance: _____ Policy/Member #: _____

Circle any of the following that apply: Diabetes Seizures Asthma Heart Condition Allergies

Any medications currently being taken: _____

Any allergies to medications: _____

In case of a serious injury requiring immediate attention school district employees are authorized to give first aid and obtain treatment or emergency hospital care.

Signature of Parent or Guardian: _____ Date: _____

To be completed by the ***School Nurse*** **only**

I have received PHYSICIAN'S **CLEARANCE** AND PHYSICAL REPORT: _____
Nurse's signature

Notes: _____

_____

Sport: _____ Date of Physical: _____