

EMERGENCY INFORMATION

STUDENT NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ AGE \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ GRADE \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_

NAME \_\_\_\_\_ RELATION \_\_\_\_\_ PHONE \_\_\_\_\_

NAME \_\_\_\_\_ RELATION \_\_\_\_\_ PHONE \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_

POLICY # \_\_\_\_\_

MEDICAL CARRIER: (Sanford/Essentia/Other) \_\_\_\_\_

KNOW ALLERGIES/MEDICAL CONDITIONS/MEDICATIONS \_\_\_\_\_

PERMISSION FOR MEDICAL TREATMENT: In the event of an emergency requiring medical attention, I hereby grant permission for emergency treatment for my daughter/son. I expect an effort will be made to contact me if an emergency occurs. I understand the cost for any medical attention may not be covered or paid by school or the North Dakota High School Activities Association. I hereby state that to the best of my knowledge, the above information is true. I approve participation in athletic activities. I hereby authorize release of the information contained in this document to the school nurse, athletic director, superintendent, principal and athletic trainer.

SIGNATURE OF PARENT/GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_