HOPE ACADEMY

ATHLETIC EMERGENCY INFORMATION FORM

Student Name _____ **D.O.B.** ____ / ____ / ____ **Grade**_____

Parent Name(s) _____

Address/City/State/Zip _____

Phone Numbers _____

Parent Email Addresses _____

Emergency Contact _____

Relationship _____ Phone _____

Name of Insurance Company _____

Policy Holder _____ Policy Number _____

Insurance Company Address _____

Family/Preferred Physician _____ Phone _____

Known Allergies (please list if any) _____

Permission to Provide Medical Treatment

I hereby give permission for my son/daughter _____ to undergo medical treatment for any injury he/she may sustain or acquire while engaged in the HOPE Academy Athletic Program. In the event that more serious medical services are required, I understand that attempts will be made to contact me for my consent. I understand that if my son/daughter suffers a potentially life threatening injury or illness, and in the event that I cannot be contacted within a reasonable period of time, I authorize any duly licensed medical practitioner to perform any necessary procedures to alleviate the problem.

I have had the opportunity to ask questions regarding this release and all of my questions have been answered to my satisfaction. Having understood the above agreement, I sign freely this Permission to Provide Medical Treatment.

_____

SIGNATURE OF RESPONSIBLE PARENT/GUARDIAN **DATE**

_____

PRINTED NAME OF RESPONSIBLE PARENT/GUARDIAN