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_____