MEDICAL EMERGENCY INFORMATION

ATHLETE'S NAME ____

FATHER/GUARDIAN ____

HOME ADDRESS ____

HOME PHONE: ______________________ WORK PHONE: _____________________

MOTHER/GUARDIAN ____

HOME ADDRESS ____

HOME PHONE: ______________________ WORK PHONE: _____________________

PHYSICIAN TO BE NOTIFIED _______________________________________

CLINIC _________________________________ PHONE: ______________________

HOSPITAL ____________________________PHONE: ______________________

UNUSUAL HEALTH CONDITIONS: _________YES _________NO
IF "YES" COMPLETE: _________ASTHMA/BREATHING DISORDER ________ALLERGIES
_____DIABETES _____BEE STING _____CONVULSIVE DISORDER _____OTHER

DOES THIS STUDENT CARRY MEDICINE _________YES _________NO
IF "YES" PLEASE LIST ____

IF EMERGENCY TREATMENT IS REQUIRED AND THE PARENTS CANNOT BE REACHED IMMEDIATELY, MAY THE COACHES USE THEIR OWN JUDGEMENT IN CALLING THE PHYSICAIAN LISTED ABOVE OR IF NOT AVAILABLE, AND ALTERNATE PHYSICIAN.
________YES _________NO

IF "NO", INDICATE PLAN TO FOLLOW:

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WHICH PARENT SHOULD BE CONTACTED FIRST? ___________________________

ARE THERE UNIQUE CIRCUMSTANCES REGARDING YOUR CHILD THAT THE COACH SHOULD BE AWARE OF? _______YES _______NO IF "YES" PLEASE DESCRIBE:

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PARENT SIGNATURE ____ DATE __________