

UTICA COMMUNITY SCHOOLS STUDENT ATHLETIC EMERGENCY INFORMATION CARD

NAME _____ SPORT _____ DATE _____

ADDRESS _____ PHONE NO. _____

MOTHER'S NAME _____ PHONE NO. _____

Work No.

FATHER'S NAME _____ PHONE NO. _____

Work No.

Please list two (2) emergency contacts (relatives or neighbors):

1. _____ NAME _____ PHONE NO. _____

2. _____ NAME _____ PHONE NO. _____

FAMILY DOCTOR _____ PHONE NO. _____

Medication taken regularly: _____

Allergies: _____

Does this athlete have Asthma? _____ Inhaler type _____

Previous injuries or illness that could be of concern if a medical emergency arises: _____

List all injuries that resulted in loss of playing time or practice: _____

HEALTH INSURANCE CO. NAME _____ GROUP NO. _____

CONTRACT NO. _____ SERVICE CODE _____

In the event of a serious accident or illness, I request that a representative of the School System contact me. If I cannot be reached, I request that contact be made with our family doctor and his instructions be followed in the treatment of my child. If the emergency is such that immediate medical care is necessary, I authorize the school system to transport my child to a hospital for emergency care. The hospital, their agents, or licensed physician, may administer such emergency medical treatment as they deem necessary under the circumstance.

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

I *do not* give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment. I wish the school authorities to take *no action or to:* _____

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____