

ATHLETES NAME _____ **GRADE** _____

EMERGENCY INFORMATION CARD The athletic department is seeking your permission to have your son or daughter treated at a doctor's office or hospital emergency room in the event that he or she is found in need of emergency medical treatment. If an emergency occurs every effort will be made to contact you. If such contact is not possible this card may facilitate prompt medical treatment.

I hereby give my permission for _____ to receive emergency medical treatment.
(Athlete's Name)

Date _____ Parent/Guardian Signature _____

Student Name _____ Date of Birth _____

Address _____ Phone # _____

Father's Work Phone _____ Mother's Work Phone _____

Another Contact Person _____ Phone # _____

Family Doctor _____ Phone # _____

Insurance Co. Name _____ Policy # _____
