

ST. LAURENCE ATHLETE EMERGENCY INFORMATION

ATHLETE'S NAME _____

ATHLETE'S GRADE _____ AGE _____

SPORT(S) PARTICIPATING IN _____

HOME ADDRESS (INCLUDING CITY) _____

FATHER'S NAME _____

MOTHER'S NAME _____

LEGAL GUARDIAN'S NAME _____

FATHER'S CELL NUMBER _____ HOME NUMBER _____

MOTHER'S CELL NUMBER _____ HOME NUMBER _____

LEGAL GUARDIAN'S CELL NUMBER _____ HOME NUMBER _____

PARENT/GUARDIAN EMAIL (Mandatory) _____

EMERGENCY NAME & PHONE NUMBER IF PARENTS NOT AVAILABLE

NAME _____ PHONE _____

PHYSICIAN'S NAME _____ PHONE _____

INSURANCE CO & POLICY NUMBER _____

ATHLETE WEARS CONTACTS? _____ YES _____ NO

MEDICATION(S) TAKEN & REASON _____

ALLERGIES (MEDICATION, INSECT BITES, ETC) _____

ADDITIONAL MEDICAL INFORMATION PERTINENT TO ATHLETE'S HEALTH
(ASTHMA, DIABETES, HEART CONDITION, ETC) _____

I give my consent and permission to any supervising coach or school personnel to arrange for immediate medical treatment by a licensed or certified physician, and for them to apply such emergency techniques as may be necessary to my child where the same, in their judgment, is deemed appropriate by reason for any injury sustained by my child.

Signature of Parent/Guardian _____ Date _____