DHS

Student Athlete

Medical Emergency Information

Athlete's Name: ______________________________

Sport: ______________ Grade: ________ Coach: ______________

Allergies: ______________________________

Significant Medical History: ______________________________

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Parent/Guardian: ______________________________

Work #: ____________ Home #: ____________ Cell #: ____________

Emergency Contacts (other than parent/guardian):

Name/Relationship: ______________________________

Work #: ____________ Home #: ____________ Cell #: ____________

Name/Relationship: ______________________________

Work #: ____________ Home #: ____________ Cell #: ____________

Physician: ______________________ Phone: ______________

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Insurance Information:

Insurance Company: ______________________________

Members Name: ______________________________

ID Number: ________________ Group Number: ______________

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I here by give my permission for the school to obtain medical treatments in case the named student suffers illness or accident and the parent/guardian/contact cannot be reached.

Date: ____________ Signature: ______________________