HEALTH INFORMATION

Parent's Statement: I accept responsibility for notifying the school of any changes of home or business address or phone number. In the event of serious illness or accident and I cannot be immediately contacted, I give my permission to have my child moved by ambulance or other conveyance to a doctor's office or hospital for immediate attention. I also assume responsibility for payments of same. In case of an accident or illness where immediate treatment is not needed, but where my child is unable to remain at school, I request the school to contact me. If I am unable to be reached, I request that one of the persons listed below be contacted to care for my child until I can be reached.

Date ____________________ Signature of Parent or Guardian ______________________________

Person(s) who will care for student in case parent cannot be reached:

Name ______________ Relationship ___________ Phone (Home) _______ Phone (Work) _______

Name ______________ Relationship ___________ Phone (Home) _______ Phone (Work) _______

Please check if athlete has had problems with any of the following:

- ❑ Diabetes
  Medication _____________
- ❑ Severe Allergies
  Specify: _____________
  ____
- ❑ Asthma
  Medication _____________
- ❑ Kidney Disease
- ❑ Heart Disease
- ❑ Epilepsy
  Medication _____________
- ❑ Sickle Cell Disease or Trait
  Medication _____________
- ❑ Seizures
- ❑ Specify: _____________
- ❑ Ears
- ❑ Speech
- ❑ Glasses/Contacts
- ❑ Hearing Aid
- ❑ Concussions
  Followed up by Physician
- ❑ Any other conditions requiring observation:
  ____
  ____
  ____
- ❑ Medications
  ____
  ____
  ____

Family Physician ____________________

Phone ____________________

Family Dentist ____________________

Phone ____________________

Preferred Hospital ____________________

APPENDIX BB

ATHLETIC EMERGENCY CARD

Date ____________________ Date of Birth ____________________

Grade ____________________ Social Security # ____________________

STUDENT'S FULL LEGAL NAME: ____
Last First Middle

Name of School: ____

Home Phone: ____________________ Address: ____
Street City Zip Code

Parent's email address: ____

STUDENT LIVES WITH: **CUSTODY RESTRICTION ☐ Please Check**

Father: Natural ☐ Step ☐ Foster ☐ Please check one

____
Name Home Phone Cell Phone Work Phone

Mother: Natural ☐ Step ☐ Foster ☐ Please check one

____
Name Home Phone Cell Phone Work Phone

Guardian (if different from above)

____
Name Home Phone Cell Phone Work Phone

INSURANCE:
Primary Carrier ____________________ Policy Number ____________________

School Insurance ☐ Football Insurance ☐ Policy Holder ____________________

PLEASE TURN OVER