APPENDIX BB

ATHLETIC EMERGENCY CARD

Date _____ Date of Birth _____

Grade _____

STUDENT'S FULL LEGAL NAME: _____
Last First Middle

Home Phone: _____ Address: _____
Street City Zip Code

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 _____

MIS 328 10/08

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 _____
☐ Seizures
Specify: _____
☐ Ears
☐ Speech
☐ Glasses/Contacts
☐ Hearing Aid
☐ Concussions
Followed up by Physician
☐ Any other conditons requiring observation:
_____
_____
_____
☐ Medications
_____
_____

Family Physician _____

Phone _____

Family Dentist _____

Phone _____

Preferred Hospital _____