

# MEDICAL EMERGENCY INFORMATION

ATHLETE'S NAME \_\_\_\_\_

FATHER/GUARDIAN \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

MOTHER/GUARDIAN \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

PHYSICIAN TO BE NOTIFIED \_\_\_\_\_

CLINIC \_\_\_\_\_ PHONE: \_\_\_\_\_

HOSPITAL \_\_\_\_\_ PHONE: \_\_\_\_\_

UNUSUAL HEALTH CONDITIONS: \_\_\_\_\_ YES \_\_\_\_\_ NO

IF "YES" COMPLETE: \_\_\_\_\_ ASTHMA/BREATHING DISORDER \_\_\_\_\_ ALLERGIES  
\_\_\_\_\_ DIABETES \_\_\_\_\_ BEE STING \_\_\_\_\_ CONVULSIVE DISORDER \_\_\_\_\_ OTHER

DOES THIS STUDENT CARRY MEDICINE \_\_\_\_\_ YES \_\_\_\_\_ NO

IF "YES" PLEASE LIST

\_\_\_\_\_

IF EMERGENCY TREATMENT IS REQUIRED AND THE PARENTS CANNOT BE REACHED IMMEDIATELY, MAY THE COACHES USE THEIR OWN JUDGMENT IN CALLING THE PHYSICIAN LISTED ABOVE OR, IF NOT AVAILABLE, AND ALTERNATE PHYSICIAN.

\_\_\_\_\_ YES \_\_\_\_\_ NO

IF "NO" INDICATE PLAN TO FOLLOW:

\_\_\_\_\_

\_\_\_\_\_

WHICH PARENT SHOULD BE CONTACTED FIRST? \_\_\_\_\_

ARE THERE UNIQUE CIRCUMSTANCES REGARDING YOUR CHILD THAT THE COACH SHOULD BE AWARE OF? \_\_\_\_\_ YES \_\_\_\_\_ NO IF "YES" PLEASE DESCRIBE:

\_\_\_\_\_

PARENT SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_