

PREPARTICIPATION EVALUATION

EMERGENCY TREATMENT FORM

To All Parents/Guardians:

Many hospitals and doctors will not treat a child without parent's consent (unless a matter of life or death). It is requested that you complete the information below so that if your child requires a visit to the hospital while under the supervision of the school, this will allow the hospital to treat the injury.

EMERGENCY INFORMATION

Name: _____ Sport(s): _____ 2010-2011 Grade: _____

Sex: M _____ F _____ Age: _____ Date of Birth: ____/____/____ Social Security Number: _____

Mother's Name: _____

Work Phone #: _____ Cell Phone #: _____

Father's Name: _____

Work Phone #: _____ Cell Phone #: _____

Home Address: _____

Home Phone #: _____ E-Mail: _____

Secondary Emergency Contact: _____

Relationship: _____ Phone #: _____

Insurance Name: _____ Insurance #: _____

Policy #: _____ Group #: _____

Primary Care Physician: _____ Phone #: _____

Allergies: _____

List Emergency Medical Conditions: (Asthma, Diabetes, Seizures, etc.) _____

I. Consent Statement: Authorizing Treatment

I hereby give my consent for (student's name) _____ to be treated in the event of an emergency, injury or illness.

Name of Parent/Guardian: _____

Parent/Guardian Signature: _____

II. Consent Statement: Representing School

I hereby give my consent for (student's name) _____ to represent (school's name) _____ in the sport of _____.

Name of Parent/Guardian: _____

Parent/Guardian Signature: _____