

ATHLETIC EMERGENCY INFORMATION
To Accompany Each Team

For Office Use Only

Please Print

Student's Name _____ Birthdate _____ Circle Grade: 9 10 11 12

Address _____
Last City Zip Home Phone () _____

Father/Guardian _____ Work Phone () _____ Cell # () _____

Mother/Guardian _____ Work Phone () _____ Cell # () _____

The following information is required in the event your student becomes ill or is injured at school or at school sponsored events. Give names of responsible adults who can be contacted in an emergency when you cannot be reached.

Name _____ Daytime Phone () _____ Relationship _____

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Describe any *significant* health condition _____

Name of physician / clinic _____ Medical Insurance Company _____ Medical ID # _____

Address _____ Phone _____

Name of dentist _____ Phone _____

California State code requires a parent/guardian to inform the school of any medication a student is taking on a regular basis, current dosage and the name of the prescribing physician _____

In the event you cannot be reached, do you give permission for the school to obtain the necessary medical aid, including ambulance service if needed, at your expense?

Yes ____ No ____

If NO, indicate the action you want school authorities to take? _____

Signature of parent/guardian _____

Date _____

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