South Central Athletics Emergency Information Card

Athlete Name:____ Birthdate:_____________Grade:_______Sex: M F
Parent(s) Name(s):_______________________________Primary Phone:_______________Second Phone:_______________
Home Address:____Town:_______________________Zip:_______________
Insurance Company/Address:____
Policy #:________________________________Group #:______________________Policyholder:_________________________
MEDICAL HISTORY
Are you allergic to any drugs? Y N If Yes, Explain:____
Do you have any allergies? Y N If Yes, Explain:____
Are you on any medication? Y N If Yes, Explain:____
Do you wear glasses? Y N Contacts? Y N Family Physician:_________________Family Dentist:_________________
Previous major injuries/illness/conditions:____

IN CASE OF EMERGENCY, PLEASE CONTACT (IN ORDER OF PREFERENCE):

1.Name:_________________________Relation:______________Phone 1:__________________Phone 2:_________________
2. Name:_________________________Relation:______________Phone 1:__________________Phone 2:_________________
3. Name:_________________________Relation:______________Phone 1:__________________Phone 2:_________________

I hereby give my permission for the school to obtain the services of a dentist, physician, and/or hospital in case the above named student suffers illness and/or accident and the parents/guardians cannot be contacted. I authorize the school officials to take whatever actions considered to be in the best interest of my child. I also understand that a copy of this document will be deemed valid as it's originals.
Parent Signature:____Date:_______________

South Central Athletics Emergency Information Card

Athlete Name:____ Birthdate:_____________Grade:_______Sex: M F
Parent(s) Name(s):_______________________________Primary Phone:_______________Second Phone:_______________
Home Address:____Town:_______________________Zip:_______________
Insurance Company/Address:____
Policy #:________________________________Group #:______________________Policyholder:_________________________
MEDICAL HISTORY
Are you allergic to any drugs? Y N If Yes, Explain:____
Do you have any allergies? Y N If Yes, Explain:____
Are you on any medication? Y N If Yes, Explain:____
Do you wear glasses? Y N Contacts? Y N Family Physician:_________________Family Dentist:_________________
Previous major injuries/illness/conditions:____

IN CASE OF EMERGENCY, PLEASE CONTACT (IN ORDER OF PREFERENCE):

1.Name:_________________________Relation:______________Phone 1:__________________Phone 2:_________________
2. Name:_________________________Relation:______________Phone 1:__________________Phone 2:_________________
3. Name:_________________________Relation:______________Phone 1:__________________Phone 2:_________________

I hereby give my permission for the school to obtain the services of a dentist, physician, and/or hospital in case the above named student suffers illness and/or accident and the parents/guardians cannot be contacted. I authorize the school officials to take whatever actions considered to be in the best interest of my child. I also understand that a copy of this document will be deemed valid as it's originals.
Parent Signature:____Date:_______________