ATHLETIC MEDICAL CARD

SPORT:_____ SEASON:_____

STUDENT'S NAME_____ DOB:_____

Mailing Address:_____

Telephone:_____

PARENT/GUARDIAN who is legally responsible for this child:

NAME:_____

Address:_____

Home Phone:_____ Cell Phone:_____

***WHERE CAN PARENT(S) BE REACHED IF NOT AT HOME:**

MOTHER'S NAME:_____ EMPLOYMENT:_____

Work Phone:_____ Cell Phone:_____

FATHER'S NAME:_____ EMPLOYMENT:_____

Work Phone:_____ Cell Phone:_____

Family Doctor:_____ Phone #_____

Insurance Carrier:_____Policy #_____

Family Dentist:_____ Phone #_____

DOES YOUR CHILD HAVE ANY OF THE CONDITIONS LISTED BELOW:

Any Known allergies Yes _____ No _____
If yes, type of allergy _____
Heart Disease Yes _____ No _____
Convulsive Disorder Yes _____ No _____
Diabetes Yes _____ No _____
Other Chronic Illness Yes _____ No _____
If yes, please explain _____

Is your child on any special medication Yes _____ No _____

Has your child had any serious accidents or illnesses within the last year? Yes _____ No _____

If yes, what: _____

Date of last tetanus: _____

In case of accident or serious illness I request the school t attempt to contact me. If the school is unable to reach me, I hereby authorize the school to transport my son/daughter to the nearest facility or call the nearest ambulance. If emergency medical care is required and if parental permission is not available in a timely manner, i authorize medical care as deemed necessary by medical personnel, a physician, or the medical facility providing treatment.

Signature of parent _____Date_____