

STUDENT ATHLETE: MEDICAL INFORMATION AND EMERGENCY CONSENT FORM

PARTICIPANT'S NAME:							
ADDRESS:							
CITY:	ZIP:	ZIP: PHONE:					
PARENT/LEGAL GUARDIAN:							
ADDRESS:							
EMPLOYER:							
HOME PHONE:	CELL PHONE:	CELL PHONE:			WORK PHONE:		
OTHER EMERGENCY CONTACT PERSON:					PHONE:		
MEDICAL INFORMATION					1		
FAMILY PHYSICIAN:				PHONE	PHONE:		
GROUP/ADDRESS:				THOME			
HOSPITAL OF PREFERENCE:							
HOSFITAL OF PREFERENCE.							
INSURANCE INFORMATION							
SUBSCRIBER: GROUP NUMBER							
POLICY NUMBER: COMPANY:							
PRE-EXISTING MEDICAL CONDITIONS:							
I authorize the coaching staff to p	rovide emergency medic	al treatmer	nt of any injury	to or illnes	ss by my child if au	alified medical	
personnel consider treatment nec	0 ,						
in his or her judgment may be dee	•						
in his or her judgment may be det	emed necessary in the ca	ire or (crinc	15 Hame)				
PARENT/LEGAL GUARDIAN:				1	DATE:		
By entering my full name, I attest that	t this constitutes my legal el	ectronic sig	nature on this fo	orm.			
PARENT/LEGAL GUARDIAN:					DATE:		
By entering my full name, I attest that	t this constitutes my legal el	ectronic sig	nature on this fo	orm.			