Carlynton School District Athletic Department

Emergency Medical Information and Consent Form

Name: _____

Address: _____

City, State, Zip: _____

Telephone #: (_____) _____ - _____

Blood Type: _____

Pre-Existing Circulatory/Pulmonary Conditions: _____

Allergies or Allergic Reactions: _____

Inhalers: _____

Medications: _____

Date of Tetanus Immunization: _____

Other Pertinent Medical Information: _____

_____

In case of an emergency, please contact:

Name: _____

Address: _____

Telephone #'s: (H)_____(W)_____(Cell)_____

Relationship to Student: _____

INSURANCE INFORMATION

Insurance Company _____

Policy Number _____Group Number _____

Family Physician _____Phone Number _____

I, _____, parent / guardian of _____, recognize that as a result of participation in athletics, medical treatment on an emergency basis may be necessary. I further recognize that school personnel may be unable to contact me for my consent for emergency medical care. In this case, I authorize school personnel to act on my behalf according to their best judgment in any emergency requiring medical attention for which service I will pay.

Signature of Parent / Guardian: _____Date:_____

This form must be kept with the team medical kit. It must be available at all team conditioning workouts, practices, and contests.

(Revised May 2013)