

PINE ISLAND EXTRA-CURRICULAR PARTICIPANT EMERGENCY FORM

PLEASE PRINT

Complete Legal Name _____
(First) (Middle) (Last)

Date of Birth _____
(Month, Day, Year)

EMERGENCY INFORMATION AND MEDICAL TREATMENT CONSENT

In emergency, contact _____
Phone _____, or

_____ Phone

I, _____, the parent or guardian of

Recognize that as a result of athletic participation, medical treatment on an emergency basis may be necessary and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then existing circumstance.

Allergies to
medications _____

Medications for long-term illness (indicate illness and
medications) _____

Relevant medical information (e.g., contact lens wearer; history of family diabetes, epilepsy; heart murmur)

Date _____ Grade of Athlete _____ Signature of Parent or
Guardian _____

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Insurance Information (Optional)

Name of Policy Holder _____

Insurance Company: Name _____

State _____ Zip _____ Address _____ City _____

Policy Number _____ Certificate
Number _____