CARTERET SCHOOL DISTRICT EMERGENCY MEDICAL INFORMATION

PLEASE PRINT ALL INFORMATION

Name _____ Sport _____

Date of Birth _____ Age _____ Grade _____

Street Address_____

Parent/Guardian Name _____

Home Phone _____ Work Phone _____

Cell Phone _____

Alternate person to contact if a parent/guardian cannot be reached:

Name _____ Home Phone _____

Work Phone _____ Cell Phone _____

Family Physician Name_____

Family Physician Address_____

Family Physician Phone Number_____

Insurance Information: Please indicate NONE if you do not have medical insurance.

Insurance Company _____

Policy/Group # _____

Medical History Information: Please indicate NONE if applicable.

Known Medical Problems _____

Known Allergies _____

Current Medication(s) _____

Emergency Consent Authorization

As a parent or guardian of this child, I hereby give consent for him/her to receive any necessary healthcare treatment that may be provided by healthcare providers employed directly or through a contract by the school, or the opposing team's school. In the event of a medical emergency, I hereby give consent for any treatment, diagnosis, and/or hospital care as deemed necessary by a licensed physician. This authority is granted only after a reasonable effort has been made to reach me.

_____ _____

Parent/Guardian Signature Date