EMERGENCY INFORMATION AND CONSENT FOR MEDICAL TREATMENT (To be completed by parent/guardian)

Student Name:	Last name	, , ,	First name	Middle name
Address:	<u> </u>		City/Town	Zip code
Social Security Nur			,	
Parent/Guardian:	Last name		First name	Middle name
Place of Work:				
Phones: Home		_ Work _		Cell
Parent/Guardian: _	Last name		First name	Middle name
Place of Work:				·
				Cell
Medical/Accident Insurance Carrier:				
Policy Number:				
				_
, 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.				
Please make the following notations on my son/daughter's records:				
Allergies to medications:				
Medications for long-term Illness (indicate illness and medications:				
Relevant medical information (e.g. contact lens, history of family diabetes, epilepsy, heart murmur):				