

**ATHLETIC / ACTIVITY EMERGENCY FORM**

SCHOOL YEAR - \_\_\_\_\_

*Please print in black or blue ink*

Student's Name: \_\_\_\_\_ M / F Age: \_\_\_\_ Date of Birth: \_\_\_\_\_

First MI Last

Year in School: 7<sup>th</sup> 8<sup>th</sup> 9<sup>th</sup> 10<sup>th</sup> 11<sup>th</sup> 12<sup>th</sup> Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

**Contact Info:**

Name of Parent/Guardian: \_\_\_\_\_ Address: \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Parent/Guardian E-Mail Address: \_\_\_\_\_

Other Emergency Contact #1 / Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Other Emergency Contact #2 / Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Health Information:**

Doctor / Health Care Provider \_\_\_\_\_ Phone Number \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

Please list any medical conditions of which school staff should be aware\* \_\_\_\_\_

Medication Currently Being Taken: \_\_\_\_\_

\* If your child has Asthma, Diabetes or Life Threatening Allergies: Please provide extra emergency medication (Inhaler, EpiPen, Insulin etc.) for use during after-school hours if your child participates in sports or other extra/co-curricular activities. We are reluctant to remove the emergency medication that is stored in the school health room. If the medication does not get returned, it will not be available during school hours should it be needed. If your child is unable to safely self-carry and administer the medication the sports coach or activity supervisor can carry it. If a **Medication Request Form** is not already on file at the school, you will need to have one completed and returned to your child's school. This form is available at the school or on-line at:

[http://www.mead354.org/uploaded/District\\_Office/Student\\_Services/documents/HS\\_303\\_Medication\\_Request\\_Form.pdf](http://www.mead354.org/uploaded/District_Office/Student_Services/documents/HS_303_Medication_Request_Form.pdf)

**Please make sure that your student actually has the needed emergency medication if it is self-carried.**

I give permission for my child's participation in all activities for his/her team sport(s) or extra/co-curricular activities.

I am familiar with proposed destinations, the mode of transportation, and the leadership accompanying the team. I understand that measures will be taken to safeguard the health and safety of my child and that I will be notified as soon as possible in case of an emergency.

In event of sickness or accident, I will NOT HOLD the Mead School District or attendants responsible.

I authorize, at my expense, the calling of a doctor and/or provision of medical services, which are considered necessary. The undersigned parent/guardian of \_\_\_\_\_, a minor authorize treatment in an emergency situation of an X-ray examination, laboratory tests, anesthetic, medical or surgical procedure, or hospital care required by him/her while traveling with the team, and for which I am not able to be reached to provide consent.

Such care must be recommended by and performed under the supervision of a licensed health care provider in the United States of America.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_