

GUERIN CATHOLIC

ATHLETIC EMERGENCY INFORMATION

Name: _____ Grade: _____ Age: _____

Parent/Guardian: _____

Address: _____

Home Phone: _____ Work/Cell: _____

Family Physician: _____ Phone: _____

Orthopedic Physician: _____ Phone: _____

Hospital Preference: _____

Insurance: _____ School: _____ Other: _____

Date of last Tetanus shot: _____

Do you wear Contact Lens? Yes _____ No _____ hard _____ Soft _____

Do you have any allergies? Yes _____ No _____ If yes, what: _____

Are you on any special medications? If yes, please list _____

In the event I cannot be reached, I hereby give my consent to the attending physicians, trainer, and coaches to secure and/or administer emergency medical aid and obtain ambulance service if needed.

Yes _____ No _____ Date _____

Signature of Parent/Guardian _____