



Mount Si High School Athletic
Emergency Information

Sport: _____
 Fall Winter Spring

Student Name: _____ Grade: _____

Parent/Guardian: _____

Address: _____

City: _____ Zip: _____

Student

Home phone: _____ Cell Phone: _____

Business phone: Father: _____ Mother: _____

Cell Phone: Father _____ Mother: _____

Guardian: _____ Students Birth date: _____

In case of an emergency and you cannot be reached who should we call:

Name: _____ Phone: _____

Name: _____ Phone: _____

Preference of Physicians:

Family Physician: _____ Phone: _____

Physician: _____ Phone: _____

Hospital Preference: _____

Does your child have any health problems we should be aware of?

Major illnesses or injuries in the last 3 years:

Medications: _____

Allergies: _____

Does your child wear glasses or corrective lenses? _____

Dentists Name: _____ Phone: _____

Parent/Guardian must complete and sign reverse side.



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Students Name: _____

In case of serious injury, illness or other emergency during participation of athletics when I cannot be reached, I the parent/guardian authorize the coaching staff/athletic trainer to examine my son/daughter and in the event of injury to administer emergency care, seek medical attention from the nearest physician and arrange for any consultation by a specialist, including a surgeon, as deemed necessary to insure proper care of my child.

My signature below authorizes emergency medical treatment for my child should that become necessary in my absence.

Parent/Guardian Signature

Date

Medical Insurance: _____

Policy Number: _____

Insurance Phone: _____

Insurance Address: _____

Students Name: _____

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