FOREST HILLS EASTERN ATHLETICS
EMERGENCY CONTACT INFORMATION

NAME: _____

SPORT: _____ DATE OF BIRTH: _____

AGE: GRADE (circle one): FR SO JR SR

HOME ADDRESS: _____

PARENT/GUARDIAN'S NAME: _____

PHONES: HOME: _____ CELL: _____ WORK: _____

PARENT/GUARDIAN'S NAME: _____

PHONES: HOME: _____ CELL: _____ WORK: _____

IN AN EMERGENCY, IF PARENTS CANNOT BE CONTACTED, NOTIFY:

NAME : _____ PHONE: _____

FAMILY DOCTOR : _____ PHONE: _____

PREFERRED HOSPITAL: _____

MEDICATIONS TAKEN REGULARLY: _____

KNOWN ALLERGIES _____

ASTHMA: YES _____ NO _____ -IF YES LOCATION OF INHALER: _____

EPI PEN: YES _____ NO _____ -IF YES LOCATION OF EPI PEN: _____

The team physician, trainer, and coach may apply first aid treatment until the family doctor can be contacted.

YES _____ NO _____

We give our consent for coaches, trainers, and team physician to use their own judgment in securing medical

aid and ambulance service in case the parents cannot be reached. YES _____ NO _____

DATE _____ PARENT SIGNATURE _____