EMERGENCY MEDICAL INFORMATION

(Please print all information)

Name: ______________________ Sport: ______________ Date of Birth: ____________

Grade (circle one): FR SO JR SR

Home Address: ____

City Zip

Mother's Name: ______________________ Cell Phone: _____________ Work Phone: __________

Father's Name ______________________ Cell Phone: _____________ Work Phone: __________

Health Insurance Co: ____

Emergency Contact: ___________________ Phone Number: ______________________

Medications Taken Regularly: ____

Allergic to any Medications: NO ____ Yes ____ If yes, please list: ______________________

Asthma: NO ____ Yes ____ - If yes, location of inhaler ______________________________

Epi Pen: NO ____ Yes ____ - If yes, location of epi pen ______________________________

Other Medical Conditions: ____

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