BROTHER RICE HIGH SCHOOL ATHLETIC DEPARTMENT

EMERGENCY PROCEDURE CARD

STUDENT'S NAME _____ YEAR _____
(LAST) (FIRST) (MIDDLE)

ADDRESS _____ CITY _____ ZIP _____

STUDENT I.D. # _____ SOCIAL SECURITY # _____ DATE OF BIRTH __/__/____ AGE _____ GENDER _____

STUDENT LIVES WITH (CHECK ONE) ___*PARENTS* ___*FATHER* ___*MOTHER* ___*GUARDIAN*

FATHER'S / MALE GUARDIAN'S NAME _____ PLACE OF EMPLOYMENT _____

HOME PHONE (___)_____ BUSINESS PHONE (___)_____

CELL PHONE (___)_____ PAGER (___)_____

MOTHER'S / FEMALE GUARDIAN'S NAME _____ PLACE OF EMPLOYMENT _____

HOME PHONE(___)_____ BUSINESS PHONE (___)_____

CELL PHONE (___)_____ PAGER (___)_____

FAMILY PHYSICIAN NAME : _____ PHYSICIAN PHONE : (___)_____

PRIMARY INSURANCE COMPANY: _____ PRIMARY GROUP/POLICY #: _____

DOES THE POLICY COVER SPORT RELATED ACCIDENTS? ____ YES ____NO

IN AN EMERGENCY WHEN PARENT(S)GUARDIAN(S) CANNOT BE REACHED, PLEASE CONTACT THE FOLLOWING :

NAME _____ *RELATIONSHIP* _____ *PHONE (___)*_____

NAME _____ *RELATIONSHIP* _____ *PHONE (___)*_____

STATEMENT OF CONSENT:

My son _____ has my permission to participate in training, practices, competitions, events, activities and travel sponsored by Brother Rice High School for the sport of _____. I approve of the leaders and coaches who will be in charge of this sport. I recognize that the leaders and the coaches are serving to the best of their abilities. I certify that my son has full medical insurance with the company listed above. I also certify to the best of my knowledge that my son is physically fit to engage in the activities described above.

I hereby grant permission to the Principal* of Brother Rice High School to arrange for the furnishing of such medical or dental care as my son _____ might need because of an illness or injury arising while my son is in the school building or on the school premises, or when engaged or participating in school programs both at the school site and away from the school site. This permission is granted with the understanding that the occasion may arise when it may be impossible or impractical to reach or communicate with me before medical care or treatment is given. I will assume financial responsibility for the bills incurred through my insurance company.

* in the absence of the Principal, his delegated administrator or the coach of the team

Signature of Father / Male Guardian _____ Date _____

Signature of Mother / Female Guardian _____ Date _____

I DO NOT AUTHORIZE EMERGENCY MEDICAL OR DENTAL CARE FOR MY SON.

Signed: _____ Date: _____
(Parent or Guardian)

(TURN OVER TO COMPLETE REVERSE SIDE)

Immunizations (please state month and year)
Tetanus _____ Polio _____ Measles (Rubella) _____

Health History

	Yes	No	Date	Please elaborate (especially on those conditions that might be aggravated)
Allergies	___	___	_____	_____
Asthma	___	___	_____	_____
Congenital problem	___	___	_____	_____
Diabetes	___	___	_____	_____
Epilepsy	___	___	_____	_____
Heart	___	___	_____	_____
Ankle Injuries	___	___	_____	_____
Knee Injuries	___	___	_____	_____
Back Injuries	___	___	_____	_____
Head/Neck Injuries	___	___	_____	_____
Shoulder Injuries	___	___	_____	_____
Elbow Injuries	___	___	_____	_____
Wrist Injuries	___	___	_____	_____
Hand Injuries	___	___	_____	_____
Finger Injuries	___	___	_____	_____
Other Injuries	___	___	_____	_____

Height _____ Weight _____

Is there any psychosocial or physical condition for which the participant is currently under professional and/or medical care?

_____

List any known allergies: _____

Does the participant currently take any medications? NO _____ YES _____

If yes, please name the drug(s), dosage and frequency needed: _____

List and elaborate on any medical conditions the coaching staff should know: _____

_____

Please list any injuries the participant has suffered in the last three months: _____

State special instructions to follow in case of an emergency: _____

Other: _____