

Clarke Central High School
EMERGENCY INFORMATION, CONSENT, AND RELEASE

Student's Name: _____ Grade: _____
(Last) (First) (M.I.)

Student Address: _____ City: _____

Zip: _____ Age: _____ DOB: _____ Home Phone: _____

Parent/Guardian Name: _____

Cell Phone Number: Father: _____ Mother: _____

Email Address: Father: _____ Mother: _____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name (& relation): _____ Phone(s): _____

Address: _____

INSURANCE INFORMATION

Ins. Company: _____ Subscriber: _____

Address: _____

Ins. #: _____ Insurance Contact Phone #: _____

MEDICAL INFORMATION

Family Doctor: _____ Phone: _____ Last Tetanus: _____

Known Allergies: _____

Other Conditions (asthma, diabetes, previous head injuries, surgeries, vision problems, etc.)

MEDICAL CONSENT FOR TREATMENT & RELEASE OF INFORMATION

The athletic staff (athletic trainers, coaches, or other school personnel) may apply first aid treatment for any injury or injuries sustained during participation (practice/game) in interschool athletics sanctioned by Clarke Central High School, until the parent/guardian can be contacted.

Please initial: **YES:** _____ **NO:** _____

In case the parents can not be reached, we give consent for the athletic staff to use their own judgement in securing medical treatment, ambulance service, and if necessary hospital admittance, when needed, as a result of injury during participation in sanctioned practices/games scheduled by Clarke Central High School.

Please initial: **YES:** _____ **NO:** _____

As Parent(s) / Guardian(s) of _____, I/We hereby authorize the Athletic Trainers / Physicians to release information regarding the health status of my son or daughter to their coach, Athletic Trainer, and Athletic Director as it relates to their ability to participate or the care of their injuries / illness.

Please initial: **YES:** _____ **NO:** _____

Parent Signature: _____ Date: _____

Student Signature: _____ Date: _____