ECPPS ATHLETIC EMERGENCY INFORMATION CARD

Athlete: _____Classification:_____ FR_____SO_____JR_____SR

Date of Birth: _____ **Social Security #:**_____**Sport(s):**_____

Parent(s)/ Guardian(s):_____

Mailing Address: _____Home Phone #:_____

Nearest relative or friend to contact in case the above cannot be reached:
Name: _____ Relationship: _____

Phone #:_____

Athletic Information

Family Physician/Primary Care Physician: _____Off. Phone #:_____

Circle any that apply: Contact Lenses Glasses Braces Asthma Diabetes Epilepsy

Other Allergies/Conditions:_____

Parent/Guardian Information:

Father's Employer:_____ WK Phone #:_____

Father's Insurance: _____Policy #:_____

Mother's Employer: _____WK Phone#:_____

Mother's Insurance: _____Policy #:_____

Insurance Address: _____Phone #:_____

Does your insurance cover your son/daughter? ____Yes ____No
If yes, please note: Mother's ____ Father's;____

**Does your insurance require you to be seen at a particular Hospital? Yes_____ No_____
Explain:_____

If in the judgment of any representative of the school, the above student athlete needs any care and/or treatment as a result of injury or illness, I request, authorize, and consent to such care and treatment given to my son/daughter by any physician, athletic trainer, physical therapist, coach, nurse, hospital, or school representative. I agree that any physician, athletic trainer, physical therapist, coach, nurse, hospital or school representative will not be held responsible for any claim on account of such care and treatment for my son/daughter.

Parent/Guardian Signature: _____**Date:**_____