

# William S. Hart Union High School District

## Athletic Emergency Form

Please Print

Name \_\_\_\_\_ Grade \_\_\_\_\_  
Last First Middle

Parent/Guardian Name \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Parents Work #'s Father ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Mother ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

In an emergency (if parents cannot be reached) notify:

1. \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

2. \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

3. \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

**NOTE: Please state any pertinent medical information coaches or physicians should know about the student-athlete.**

**(Allergies, medications, or conditions that require immediate emergency treatment such as Epi-Pen, Glucagon, inhalers, etc.)**

Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examination or immunizations for the above-named student. In the event of an emergency arising out of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, the treatment necessary for the best interest of the above-named student may be given.

Permission is also granted to the Certified Athletic Trainer to provide the needed first aid treatment prior to the student's admission to any medical facility.

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Attention Athletes: At the conclusion of each season, you must fill out another emergency form for your next sport.**