

EMERGENCY INFORMATION

STUDENT'S NAME: _____ GRADE: _____

HOME PHONE: _____ MOTHER'S WORK PHONE: _____

FATHER'S WORK PHONE: _____

EMERGENCY CONTACTS (IF PARENT NOT AVAILABLE):

NAME: _____ PHONE: _____

NAME: _____ PHONE: _____

LOCAL DOCTOR TO BE CALLED IN AN EMERGENCY:

NAME: _____ PHONE: _____

HEALTH HISTORY UPDATE

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING:

Asthma/Allergies Yes ___ No ___

Specify: _____

Concussions(s) Yes ___ No ___

How Many? _____

Diabetes Yes ___ No ___

Seizure Disorder Yes ___ No ___

Eye or Ear Condition Yes ___ No ___

Heart Disease Yes ___ No ___

Take any Medication On a Regular Basis Yes ___ No ___

Specify: _____

SINCE LAST SPORTS PHYSICAL,

Any illnesses lasting more than a week? Yes ___ No ___

Specify: _____

Any injuries? Yes ___ No ___

Specify: _____

Operations? Yes ___ No ___

Specify: _____

Parent's Signature

Date