SHAWNEE ATHLETIC TRAINING
MEDICAL EMERGENCY INFORMATION

Athlete's Name: _____
Sport V JV F _____ Grade: _____ Age: _____
Homeroom #: _____ Height:_____ Weight:____ Date of Birth: _____ /_____/_____
Name of Parents or Guardians: _____&_____
Address:_____
City:_____
State: _____ Zip: _____ Home Phone #: _____
Dad-Work #: ( ) ____-_____ ext. ____ Dad-Mobile #: ( ) ____-_____
Mom-Work #: ( ) ____-_____ ext. ____ Mom-Mobile #: ( ) ____-_____
Emergency Phone # of Relative or Neighbors (in the event that a parent can not be reached. Please list different names and numbers in the immediate area)
1) Name: _____ Phone #: _____ Address: _____
2) Name: _____ Phone #: _____ Address: _____
3) Name: _____ Phone #: _____ Address: _____
Family Physician: _____ Office Phone #: _____
Pertinent Health Info.:

_____

_____

_____

Allergies or Reactions to Medications:

_____

_____

SHAWNEE HIGH SCHOOL – Medical Permission Release

I hereby give permission to the attending Physician and/or Athletic Trainer at the athletic activities to carry out such emergency diagnostic and therapeutic procedures as may be necessary for my child. I also permit such procedures to be carried out by the closest hospital emergency room in the event that my child is sent or taken there for emergency medical treatment.

Name of Parent/Guardian (Print): _____

Signature of Parent/Guardian: _____
Relationship to Athlete: _____ Date: _____/_____/_____
Medical Insurance Group: _____ Group #: _____
Policy #: _____ Valid Date: _____/_____/_____
Policy/Referral Policy Activation Phone #'s: _____

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