Hillsdale High School
Emergency Information

Name ________________________________ Birthdate __________________

Age ______ Parent/Guardian's Name ____

Home Phone ________________ Address ________________________________

Grade _____ Father's Phone __________________ Mother's Phone __________________

Phone # During Day ____________________

In case of emergency, if parents cannot be contacted:

Notify ____________________________________ Phone ________________________

Family Doctor ______________________________ Doctor's Phone __________________

Preferred Hospital __________________________ Allergies _______________________

While competing, do you wear contacts? __________ Use an Inhaler? ___________

Use an epi-pen? ___________

The team physician, athletic trainer, coach may apply first aid treatment until the family doctor can be contacted. YES______ NO______ We give our consent for coaches, athletic trainers, and team physician to use their own judgment in securing medical aid and ambulance service in case the parents cannot be reached.
YES ______ NO ______ We give our consent for the physician, athletic trainer, and coach to discuss relevant and necessary information regarding my son or daughter's sports related injury as it pertains to their ability to perform and or participate. YES ______ NO ______

Date ___________ Signature of parent or guardian _________________________________

This information will be kept on file in the team's medical kit in case of emergency. Any information contained on this card will be kept confidential. If you do not wish to give your consent to the last three statements, please give a phone number where we could reach you at all times. _________________

SPORT _________________________

HILLSDALE HIGH SCHOOL

CONSENT EMERGENCY TREATMENT FORM

DATE ______________________

I, ____________________________________, being the parent or legal guardian of ________________________________ give my permission for emergency medical and surgical treatment of this minor in the event that such treatment becomes necessary. I grant my permission for treatment in a licensed hospital by a licensed physician and the physician's assistants and designees including such hospital personnel as the physician may deem necessary. I understand that hospital personnel will make reasonable attempts to contact me before initiating treatment. I am aware that the practice of medicine is not an exact science and that no guarantees can be made concerning the results of treatment. The minor named in this consent may receive all treatment provided according to generally accepted standards of medical practice with the following limitations (if none, write "none"): ________________.

Signature of Parent or Legal Guardian:

____

Chronic or existing medical conditions or problems (e.g. diabetes, epilepsy):

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____

List medicines your child is now taking:

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