

CCHS EMERGENCY CONSENT TO TREAT

SPORT (S): _____

(Please list all sports you are planning on participating in for the year)

NAME: _____ **YEAR:** FR SO JR SR
DATE OF BIRTH: _____
ADDRESS: _____
PHONE: _____

FATHER'S NAME: _____
HOME #: _____
WORK #: _____
CELL #: _____

MOTHER'S NAME: _____
HOME #: _____
WORK #: _____
CELL #: _____

EMERGENCY CONTACT: _____
(Other than parent)
PHONE #: _____

FAMILY PHYSICIAN: _____
PHONE #: _____
INSURANCE COMPANY: _____
POLICY NUMBER: _____

MEDICATIONS: _____
ALLERGIES: _____
LAST TETNUS SHOT: _____
PRE-EXISTING ILLNESS, INJURY OR DISEASE: _____

In the event of a serious or potentially serious medical emergency and I cannot be contacted, I grant permission for the medical staff to seek medical attention from the nearest facility.

PARENTS SIGNATURE **DATE**

CCHS SPORTS MEDICINE