

Medical ALERT: _____
(Administrative use only)

EMERGENCY INFORMATION AND RELEASE

Athlete's Name _____ Circle one: Cabot High CJHN CJHS FA-North FA-South
Address _____ Grade (2017-2018) _____
City, ST, Zip _____ Date of Birth _____ Age _____

Parents' or Legal Guardians' Names _____
Address (if different from above) _____ Home phone _____
Mom Work phone _____ Mom Cell phone _____
Dad Work phone _____ Dad Cell phone _____

Emergency Contact Name _____ Relationship to athlete _____
Daytime phone _____ Evening phone _____

Preferred hospital if transfer is necessary _____
Insurance Carrier _____ Insurance phone _____
Policy # _____ Group # _____
Primary care physician _____ Phone _____

Medical allergies, conditions, current medications or any other pertinent information regarding the athlete:

In the event of an emergency and with reasonable attempts to contact the above-named individuals are unsuccessful, I hereby give consent for necessary medical treatment, including but not limited to: transfer by ambulance, contact of the physician listed above, or any team physician recognized by the school authorities. This release does not cover major surgery unless 2 licensed physicians consent and provide signatures of necessity. IF YOU **DO NOT** WISH TO CONSENT, PLEASE COMPLETE THE BOTTOM OF THIS FORM.

Parent or Guardian Signature _____ Date _____

REFUSAL OF CONSENT

I DO NOT give my consent for emergency medical treatment of my child. In the even of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to:

Parent Signature _____ **Date** _____

Witnessed by _____ **Date** _____