ALERT:_____
(Administrative use only)

EMERGENCY INFORMATION AND RELEASE

Athlete's Name_____ Circle one: Cabot High CJHN CJHS
Address_____ Grade next school year_____
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 BACK 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**_____