

FORM # 2

SCHOOL YEAR: _____

AMITY REGIONAL SCHOOL DISTRICT #5 - ATHLETIC DEPARTMENT

EMERGENCY DATA & Contact Info.

Birth Date: _____ Sport: _____ Grade _____

Student Name: _____
Last First Middle Home Telephone

Home Address: _____

Parent Email _____

PLEASE COMPLETE THE FOLLOWING:

Allergies to (stings, medications, food etc.): _____

Taking medication (please name): _____

Diabetic _____ Seizures _____ Asthma _____

Does your child require *Inhaler _____ *Epi-pen _____ *Other _____

MEDICATIONS(Check One): _____ SELF CARRY _____ COACH CARRY

***School Medication Authorization must be on file in the Health Office (New Form Each School Year)**

****Students without self-administration authorization must provide the Coach with properly labeled medication separate from the nurse's medication**

Father's Name Employer & Business Address Business/Cell Phone

Mother's Name Employer & Business Address Business/Cell Phone

Family Doctor: _____ Telephone: _____

Family Dentist: _____ Telephone: _____

Hospital Preference: _____ Telephone: _____

Please list below persons readily available whom we may call if parents are unavailable:

1. _____ Telephone: _____

2. _____ Telephone: _____

3. _____ Telephone: _____

You have my permission to take whatever action you deem necessary for the health and welfare of my child in case of an emergency.

Parent's Signature

Date

IN CASE OF CHANGES IN THE ABOVE INFORMATION, PLEASE NOTIFY: COACH, TRAINER, NURSE