# Student Athlete Emergency Contact Information
# Randall High School Athletics
# 2017-2018

(If any changes occur during the year, please notify the Athletic Trainer on staff)

**Please Print or Type:**

Student's Name: _____ Age: _____ Sex: M F

DOB: ___/___/_____ Home Phone: _____ Cell Phone: _____

Grade ***(2017-2018)*** please circle: 7th 8th 9th 10th 11th 12th

Parent/Guardian Names: _____ Home Phone: _____

Address: _____ City: _____

Work Phone (mother): _____ Cell Phone (mother): _____

Work Phone (father): _____ Cell Phone (father): _____

EMERGENCY CONTACT: _____ Relationship: _____

Emergency Contact Phone: _____

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**INSURANCE INFORMATION**

Name of Family Health Care Plan: _____

Address: _____ City: _____ State: _____

Phone Number: _____ Group Policy Number: _____

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**PHYSICIAN INFORMATION**

Name of Family Physician: _____ Phone Number: _____

Office Address: _____ City: _____ State: _____

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**MEDICAL INFORMATION**

Please list any known allergies (medications, foods, sinus, etc). Be Specific: _____

_____

List all medications that you are currently taking and why: _____

_____

List any serious illness/injuries you have had in the past: _____

_____

Please list any other medical conditions you have: _____

_____

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The team physician, athletic trainer or coach may provide immediate injury care in the event of injury. Y N

I give my consent for the team physician, athletic trainer or coach to use their own judgment in securing medical aid and ambulance service Y N

I give my consent for the team physician, athletic trainer, coach to give student over the counter Medications to provide relief from ailments if deemed necessary. Y N

Student Signature: _____ Parent/Guardian Signature: _____

**Completed form must be signed by parent and student, and returned to athletic trainer before participation will be allowed. A photocopy is considered as effective and valid as the original.**