

NAME OF ATHLETE _____ Male _____ Female _____
(Last) (First)

SOUTH PLAINFIELD PUBLIC SCHOOLS
ATHLETIC OFFICE--EMERGENCY MEDICAL INFORMATION
(Please print)

Date of Birth _____ School _____ Grade _____

Student's Home Address _____ Home Phone _____ Cell Phone _____

Father/Guardian _____ Mother/Guardian _____
(Name) (Name)

Address _____ Address _____

Home Phone _____ Cell Phone _____ Home Phone _____ Cell Phone _____

Place of Employment _____ Place of Employment _____

Address _____ Work Phone _____ Address _____ Work Phone _____

Please provide contact information for a responsible relative/adult who can be notified and can give permission for emergency treatment, if needed:

Name _____ Home # _____ Work # _____ Cell # _____

OVER

Family Physician _____ Address _____ Phone # _____

Eyeglasses: _____ Yes _____ No

Contacts: _____ Yes _____ No

List any allergies which your child may have: _____

List any medication(s) your child is taking: _____

List any allergic reactions the school should be aware of: _____

When was your child's last tetanus shot? _____

Hospital preference in the case of an emergency: _____

List any other emergency information which may be helpful: _____

OPTIONAL: Please sign the following statement if you are willing and agreeable:

I/we _____ do hereby give permission for the attending emergency physician to give
Name(s) of parent(s)/guardian(s)

medical assistance to my/our child, _____, in the case of an emergency in my/our absence.
Child's name

Signature of Father/Guardian

Signature of Mother/Guardian

Date