Emergency Information

STUDENT-ATHLETE _____ DOB _____

MOTHER/GUARDIAN _____

CELL# _____ HOME/WORK#_____

FATHER/GUARDIAN_____

CELL# _____ HOME/WORK# _____

Should my son/daughter require emergency medical attention he/she has the following physical or medical limitations, including allergies and prohibited medicine: _____

_____ Initial here if you authorize the ATC and/or members of the athletic department to give one or more of the following over the counter medications as needed, in accordance with the directions for use on the container.

_____ Tylenol _____ Advil _____ Aspirin _____ Motrin

_____ Any other medications your child may need
List provided items: _____

Additional persons allowed to care for student-athlete in case parent/guardian cannot be reached:

NAME: _____ PHONE# _____

NAME: _____ PHONE# _____

PHYSICIAN: _____ PHONE# _____