

Last Name: _____ First Name: _____ Grade: _____

THE WEBER SCHOOL
ATHLETICS EMERGENCY INFORMATION/MEDICAL TREATMENT CONSENT
2010-2011

EMERGENCY CONTACT INFORMATION

STUDENT _____
Last Name First Name Birthdate Grade

ADDRESS: _____ **HOME PHONE:** _____
_____ **SOCIAL SEC #:** _____

PARENTS' NAMES: _____ and _____
PHONE #1 _____
PHONE #2 _____
OTHER _____

Person other than Parent/Guardian to be contacted in an emergency:

NAME: _____ **RELATIONSHIP:** _____
PHONE #1: _____ **PHONE #2:** _____

Does this person have permission to release your child from school? _____

FAMILY PHYSICIAN _____ **PHONE:** _____
FAMILY DENTIST _____ **PHONE:** _____

ANY SEVERE ALLERGIC REACTIONS (bee stings, pollen, food, or other): _____

KNOWN ALLERGIES TO MEDICATIONS: _____

CURRENT MEDICATIONS (include reason): _____

RELEVANT MEDICAL INFORMATION (i.e.: history of family diabetes, epilepsy, asthma, seizures, nosebleeds, heart conditions):

CONSENT TO TREAT:

As a result of athletic/school participation, medical treatment on an emergency basis may be necessary and I further recognize that school personnel may be unable to contact me for my consent to emergency care. I do hereby consent in advance to give The Weber School the authority to transport my child to the hospital and get my child emergency care, including hospital care, as may be deemed necessary under the existing circumstance.

Signature of Parent/Guardian _____ **Date** _____

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Does your child carry an Epi Pen? _____ If so, please send one to keep in the school office.

In the event that your child needs the following, do you give permission for your child to take?

Acetaminophen: _____ Ibuprofen: _____

Antihistamines: _____ Antacid Tablets: _____

In the event that your child needs basic first aid, do you give permission for your child to be administered basic first aid (such as Neosporin, cough drops) by the office staff?

Please describe any other important facts about your child's physical and emotional health that school personnel should know.

Parent/Guardian Signature: _____ Date: _____

INSURANCE INFORMATION

Health Insurance Co. _____ Policy Holder _____

Insurance Co. Address: _____

Insurance Co. Phone Number: _____

Member ID _____ Group Number _____ PCP Telephone _____