

CATHOLIC CENTRAL ATHLETIC DEPARTMENT

EMERGENCY INFORMATION FORM

This form provides appropriate information for coaches, athletic trainers, and healthcare professionals to provide emergency care for treatment of an illness or injury. The team head coach is required to have this form available at practices, contests, and while traveling with the team.

Student Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Phone Numbers for Emergencies: \_\_\_\_\_

Two Alternate Contacts:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Student's medical allergies, devices, long-term medications: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Medical Insurance Company: \_\_\_\_\_

Students' Primary Care Physician or Office: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

In the event of injury or illness, I consent to necessary Emergency Care for the student named above, as determined by on-site caregivers and hospital staff. I consent to the release of this information, otherwise protected by FERPA and HIPPA, to assist healthcare providers in emergency treatment.

Parent/Guardian Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

**PROVIDE THIS COMPLETED FORM TO YOUR CHILD'S COACH.**