

**MANCHESTER ESSEX REGIONAL SCHOOL DISTRICT
ATHLETIC DEPARTMENT**

EMERGENCY INFORMATION AND MEDICAL HISTORY

Athlete's Name _____ Birth Date __/__/____ YOG _____

Home Address _____

Home Telephone _____

PARENTS OR LEGAL GUARDIANS

Mother's Name _____

Home Phone _____ Work _____ Cell _____

Father's Name _____

Home Phone _____ Work _____ Cell _____

Other persons who may be contacted in case of emergency:

Name: _____ Phone # _____

Name: _____ Phone # _____

Family Doctor _____ Telephone _____

Insurance _____ Account # _____

Please list students medical history:

Medications student is currently taking

1. _____ (med.) _____

2. _____ (med.) _____

I, _____, the parents or guardian of _____

recognize that as a result of athletic participation, medical treatment on an emergency basis may be necessary and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, as may be deemed necessary under the then existing circumstances.

Date: _____ Signature of Parent or Guardian _____