STUDENT INFORMATION (must be completed each year) Date_____

Student Name_____Birth Date_____Race_____Sex_____Grade_____

Student Name_____Birth Date_____Race_____Sex_____Grade_____

Student Name_____Birth Date_____Race_____Sex_____Grade_____

Father Name_____Phone Number_____

Physical Address_____

Mailing Address_____

Email Address_____

Employer_____Work Phone_____

Mother Name_____Phone Number_____

Physical Address_____

Mailing Address_____

Email Address_____

Employer_____Work Phone_____

SCHOOLWIDE EMERGENCY(Weather,Intruder,Disaster,etc.) NOTIFICATION CELL NUMBER for Automated TEXT from School Messenger is:_____

If emergency service involving medical action or treatment is required & the parent(s)/guardian(s) emergency contact cannot be contacted, I/we hereby consent for the above named student to be given medical care by the physician or hospital selected by the school, if unable to contact my preference. I/we give permission for the trainer, coach, and qualified (First Aid Certified) school personnel to apply first aid treatment until the family doctor can be contacted. I/we give our consent for athletic trainers to evaluate & provied ongoing treatment and assessment for sports injuries.

EMERGENCY CONTACT - OTHER THAN PARENT

Name_____Relationship_____

Phone Number_____List Medications Used_____

Medical Considerations_____

Hospital Preference_____Family Physician_____

Allergies_____Insurance Carrier_____

I/we give our child permission to travel with the team or group on school sanctioned contests & activities. Vision/Hearing screening is conducted as part of the Office of Public Instruction's Hearing Conservation Program. I/we give consent for my child(ren) to have their vision/hearing screened.

Parent/Guardian Signature_____