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:_____ D.O.B.:_____

Address:_____

Parent/Guardian Names & Contact Information:

(a) Name:_____
Relationship:_____
Emergency Phone #:_____
Email:_____

(b) Name:_____
Relationship:_____
Emergency Phone #:_____
Email:_____

Two Alternate Contacts:

(a) Name:_____
Relationship:_____
Emergency Phone #:_____
Email:_____

(b) Name:_____
Relationship:_____
Emergency Phone #:_____
Email:_____

Student's medical allergies, devices, long-term medication:_____

_____

_____

Medical Insurance Company:_____

Student's Primary Care Physician or Office:_____

Doctor's Name:_____

Office Phone #:_____

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