CRAWFORD CENTRAL SCHOOL DISTRICT
ATHLETIC DEPARTMENT

TREATMENT/FIRST AID/EMERGENCY AUTHORIZATION FORM

NAME OF SPORT:_____

STUDENT NAME:_____DATE:_____

AGE:_____BIRTHDAY:_____GRADE:_____ MALE/FEMALE

PARENT(S) / GUARDIAN(S) NAME:_____

ADDRESS:_____ HOME PHONE:_____

CITY/ STATE / ZIP:_____ WORK PHONE:_____

PARENT(S) / GUARDIAN(S) NAME:_____

(IF DIFFERENT THAN ABOVE)

ADDRESS:_____ HOME PHONE:_____

CITY/ STATE / ZIP:_____ WORK PHONE:_____

NEAREST NEIGHBOR / RELATIVE TO CONTACT:_____

CONTACTS PHONE NUMBER ( )_____

FAMILY DOCTOR:_____PHONE:_____

HOSPITAL:_____ PHONE:_____

INSURANCE COMPANY:_____

POLICY NUMBER:_____

I, _____, Hereby give my permission to the athletic trainer

(Parent/Guardian)

to evaluate and treat my son/daughter in case of injury or illness.

I, _____, give my consent to the hospital or physician to perform or administer emergency care and treatment to my son/daughter.

ADDITIONAL CELL PHONE NUMBERS

1._____ 2._____