

**EAST GRAND RAPIDS HIGH SCHOOL
ATHLETIC OFFICE
Emergency Information**

NAME _____ BIRTH DATE _____ AGE _____

HOME ADDRESS _____ PHONE/CELL _____

PARENT/GUARDIAN'S NAME: FATHER _____ MOTHER _____

PHONE NUMBERS _____

IN AN EMERGENCY (IF PARENTS CANNOT BE REACHED) PLEASE CONTACT:

NAME _____ PHONE NUMBER _____

FAMILY PHYSICIAN _____ PREFERRED HOSPITAL _____

KNOWN ALLERGIES _____

CURRENT MEDICATIONS _____

The team physician, athletic trainer, or coach may administer first aid until the family physician can be contacted: YES NO

We give our consent for coaches, athletic trainers and team physicians to use their own judgment in securing medical aid and ambulance service in case the parents cannot be reached: YES NO

PARENT SIGNATURE _____

DATE _____

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