

**HARDIN COUNTY SCHOOLS ATHLETICS/BAND
EMERGENCY INFORMATION SHEET**

PLEASE PRINT CLEARLY

ATHLETE'S NAME: _____ BIRTHDATE: _____ DATE: _____
MOTHER'S NAME: _____ HOME # _____ AGE: _____
ADDRESS: _____ CELL # _____
FATHER'S NAME: _____ HOME # _____ CELL # _____
ADDRESS: _____

IN AN EMERGENCY, IF THE PARENTS CANNOT BE CONTACTED, PLEASE NOTIFY:

NAME: _____ HOME # _____ CELL # _____
FAMILY DOCTOR: _____ DOCTOR'S PHONE: _____
PREFERRED HOSPITAL _____ KNOWN ALLERGIES _____

THE TEAM PHYSICIAN, TRAINER, OR COACH MAY APPLY FIRST AID TREATMENT UNTIL THE FAMILY DOCTOR
CAN BE CONTACTED: YES _____ NO _____

WE GIVE OUR CONSENT FOR THE COACHES, TRAINERS, AND TEAM PHYSICIAN TO USE THEIR JUDGEMENT
IN SECURING MEDICAL AID AND AMBULANCE SERVICE WHEN THE PARENTS CANNOT BE REACHED:
YES _____ NO _____

PARENT'S SIGNATURE

DATE

TYPE OF INSURANCE _____

POLICY # _____

NAME: _____

LAST TETANUS SHOT _____

HEALTH HISTORY

KIDNEY INJURY
HEART CONDITION OR DISEASE
DIABETES
ASTHMA

YES NO

LIST MEDICATION YOU ARE ALLERGIC TO:

LIST MEDICATION YOU TAKE REGULARLY:

WHILE COMPETING DO YOU WEAR:

ORTHODONTIC DEVICES?
GLASSES?
CONTACT LENSES?

1. I, _____ FOR _____ HEREBY
PARENT'S NAME ATHLETE'S NAME

CONSENT TO SUCH CARE AT A HOSPITAL, AND SUCH DIAGNOSIS PROCEDURES AND MEDICAL TREATMENT
BY THE ATTENDING PHYSICIAN IN THE EMERGENCY DEPARTMENT AT SAID HOSPITAL AND THEIR DESIGNATE:
AS IS NECESSARY ON THEIR JUDGEMENT.

2. I HEREBY AGREE TO HOLD THE STAFF OF HARDIN COUNTY SCHOOLS
BOARD OF EDUCATION HARMLESS FROM ANY LIABILITY RESULTING FROM ANY OF THE SAID MEDICAL
TREATMENT.

3. I FURTHER HEREBY AUTHORIZE ANY MEMBER OF THE HARDIN COUNTY SCHOOLS
TO SIGN ANY AND ALL NECESSARY RELEASES, DOCUMENTS, OR AUTHORIZATIONS FOR
TO RECEIVE ANY AND ALL NECESSARY EMERGENCY TREATMENT.

ATHLETE'S/PERFORMER NAME

PARENT'S SIGNATURE _____

DATE _____