EMERGENCY INFORMATION & CONSENT

Athlete's Name: ______________________ Nickname:_________________
Address:____
Phone:_________________________ Work/Cell:____________________
Father's or Guardian's Name:___________________________________
Address (if different):____
Employer: ____
Phone: ______________ Work: ______________ E-mail: _____________
Mother's or Guardian's Name: __________________________________
Address (if Different): ____
Employer:____
Phone: ______________ Work: ______________ E-Mail: _____________

Family Medical Insurance

Carrier: _______________________ Group: _______________________
Policy #: ______________________ Group # ______________________
Family Physician's Name: _______________________________________
Physician's Address: ____
Physician's Phone #: ____
Allergies (list): ____
____
Serious Medical Conditions (list):_________________________________
Any medical conditions that we should be aware of to help your child enjoy the sport: ____
____
Current medications (list):
____
____

I/we hereby grant consent to any and all health care providers designated by Clarksburg Sports Association to provide my child ____________________ any necessary medical care as a result of any injury/illness. This consent includes First Aid and transportation to/from health care providers.

Date ___________ Father's/Guardian's Signature: ____________________

Date ___________ Mother's/Guardian's Signature: ____________________