

NAME _____
LAST FIRST

GRADE _____ SPORT _____



CENTRAL BUCKS SCHOOL DISTRICT - DOYLESTOWN, PENNSYLVANIA

EMERGENCY INFORMATION AND CONSENT

Student Address: _____ DOB: _____

Parent/Guardian: _____ Home Phone: _____

Day Phone: Father: _____ Mother: _____

Cell Phone: Father: _____ Mother: _____

PERSON TO CONTACT IN CASE OF EMERGENCY, OTHER THAN PARENT OR GUARDIAN:

Name (& relation): _____ Phone: _____

INSURANCE INFORMATION

Insurance Company _____ Subscriber: _____

Policy/Group #: _____

Pre-authorization Phone # (if needed): _____

MEDICAL INFORMATION

Family Doctor: _____ Phone: _____

Last Tetanus Shot: _____ Wears Glasses or contacts: _____

Chronic Conditions (i.e. asthma, diabetes, heart abnormalities etc.): _____

Any known allergies: _____

Current medications (include inhalers): _____

Other pertinent information: _____

MEDICAL CONSENT FOR TREATMENT

To whom it may concern:

The athletic staff (athletic trainer, coaches, or other school personnel) may apply first aid treatment for any injury or injuries sustained during participation in interschool athletics sanctioned by Central Bucks School District.

YES: _____ **NO:** _____

In the event of an emergency requiring medical attention every effort will be made to contact me before any treatment or hospitalization is undertaken. In case we cannot be reached, we give consent for the athletic staff to use their own judgment in securing medical aid, ambulance service, and if necessary hospital admittance.

YES: _____ **NO:** _____

STATEMENT REGARDING ACCIDENT INSURANCE WAIVER

We the undersigned are completely aware that the Central Bucks School District DOES NOT provide accident insurance for ANY students participating in athletic programs beginning July 1, 20__ and assumes NO LIABILITY for injuries sustained from participation. We hereby affirm that we assume the full responsibility for payment of any medical expenses that may result from participation of _____ in athletics, including practice, and such cost will be borne by the undersigned through insurance plans to which we presently subscribe, or through personal resources.

PREFERRED HOSPITAL: _____

Parent/Guardian Signature: _____ Date: _____