

“PLEASE COMPLETE BOTH CARDS”
ST. THOMAS ATHLETICS EMERGENCY INFORMATION CARD
PLEASE PRINT CLEARLY – ALL INFORMATION IS REQUIRED

Athlete's Name: _____ Grade: 9 10 11 12 School Year: _____

List ALL Sports Participating in: _____

The Athletic Department is requesting your permission to have your son treated at a doctor's office or hospital emergency room in the event that he is found in need of emergency medical treatment. If an emergency occurs, every effort will be made to contact you. If such contact is not possible, this card may facilitate prompt medical treatment.

I hereby give my permission for _____ to receive emergency medical treatment.

Date of Birth: _____ Parent / Guardian Signature: _____

Home Address: _____ City: _____ ZIP Code: _____

Home Phone: (____) _____ Father's Name: _____ Mother's Name: _____

Father's Employer: _____ Work #: (____) _____

Mother's Employer: _____ Work #: (____) _____

Orthopedic Specialist: _____ Phone #: (____) _____

Family Doctor: _____ Phone #: (____) _____

Insurance Company: _____ Phone #: (____) _____

Policy #: _____ Group #: _____ SSN: _____ - _____ - _____

If emergency transport is necessary, what is your hospital preference, in conjunction with your health care plan?

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