# James Buchanan High School

*Athletic Department Emergency Information*

Sport: _____

Season: Fall / Winter / Spring

Year: _____

Name of Athlete: _____ Birth Date: _____

Parent / Guardian Names: _____

Athlete Lives With: _____

Home Address: _____

Phone Number: _____

Work Number for Mother: _____ Work Number for Father: _____

Work Number for Guardian: _____

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*In an Emergency if Parents / Guardian cannot be contacted:*

Notify: _____ Phone Number: _____

Family Doctor: _____ Phone Number: _____

Preferred Hospital: _____

Insurance Information – Policy Holder: _____

Insurance Name: _____ Policy Number: _____

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*DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HEALTH PROBLEMS?*

_____ Asthma (if an inhaler is required please list) _____

_____ Diabetes

_____ Seizures

_____ Headaches / Migraines

_____ Seasonal Allergies

_____ Heart Condition / Disease

_____ Bee Stings _____ Requires Epi Pen _____ Benadryl

_____ Others (PLEASE LIST) _____

While competing in sports, does your child wear: _____ Contacts _____ Glasses

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I realize the coaching staff and athletic trainer will make every attempt to contact me should my child become injured or ill.

*The team physician, athletic trainer, and coach may apply first aid treatment until I can be contacted?* _____ YES _____ NO

*I give my consent for coaches, athletic trainers, and team physician to use their judgement in securing medical aid and ambulance service in the case the parents / guardians cannot be reached.* _____ YES _____ NO

I realize the Tuscarora School District cannot be held responsible or be obligated for any cost involved.

*Parent / Guardian Signature:* _____ *Date:* _____