

AMSTERDAM JR / SR HIGH SCHOOL MEDICAL CARD / CONSENT

ATHLETE'S NAME: _____
AGE: _____

SPORT PLAYING : _____ CIRCLE LEVEL: *MODIFIED/FRESHMAN/
JV/VARSITY*

D-O-B: _____ GRADE: _____

ADDRESS: _____

CITY: _____ ZIP: _____ HOME PHONE: _____

PARENT(S): _____

CONTACT PHONE #'S:

NAME: _____ CELL: _____
WORK: _____

NAME: _____ CELL: _____
WORK: _____

EMERGENCY CONTACT (in event parents can't be reached):

NAME: _____

RELATIONSHIP: _____

PHONE #'S: HOME: _____ CELL: _____ WORK: _____

DOCTOR: _____ HOSPITAL

AFFILIATION: _____

HEALTH CONCERNS/ALLERGIES: _____

PARENT(S) INSURANCE CARRIER: _____

PARENT PERMISSION/STUDENT AGREEMENT:

Our signatures indicate:

- Permission to try out for and participate in interscholastic athletics.
- Awareness that this form will be sent to Coach and Athletic Director
- The athlete and/or parent is responsible for notifying coach, AD, and/or School Health office at time of injury.

PERMISSION FOR EMERGENCY MEDICAL TREATMENT: In the event of a medical emergency, every effort will be made to contact the parent/guardian to authorize medical treatment/hospitalization. I, hereby grant permission for a physician or hospital personnel designated by Amsterdam to attend my son/daughter if I cannot be contacted (Insurance carrier listed above).

Parent Signature: _____ Date: _____

Student Signature: _____ Date: _____