

ATHLETIC EMERGENCY CARD

TO PARENTS: Please fill out both sides of Student Emergency Card, sign and date.

Print Student Name _____ Date of Birth _____ Grade _____
 Address _____ City _____ State _____ Zip _____

Phone Numbers: Home _____
 Father _____ Work # _____ Cell # _____
 Mother _____ Work # _____ Cell # _____
 Emergency Contact Person _____ Home # _____ Cell # _____
 Physician _____ Phone _____
 Dentist _____ Phone _____

LIST KNOWN DRUG ALLERGIES _____

Will your child bring medication (prescription or over-the-counter)? YES _____ NO _____

If yes, please specify:

Name of Medication	Physician	Dosage/Frequency	Special Instructions

Parkway School District
Form # 226 (Rev. 12/06)

(OVER)

Please provide other health information which would help us meet the needs of your child. Include such conditions as: serious allergies, asthma, diabetes, ear and eye problems, heart conditions, seizure disorders, orthopedic conditions; any specialized health care needs; dietary restrictions.

Date of last DT (Diphtheria/Tetanus Immunization): _____

All medication brought by your child will be self-carried, self-administered, and must meet the following criteria:

Prescription Medication:

All medication brought must have a current prescription label properly affixed to the medication in question. The label must contain the name of the child, name of drug, dosage, frequency of administration, diagnosis, and physician's name.

Over-the-counter Medication:

This medication must be in the original bottle. Place child's name on bottle.

IN CASE OF EMERGENCY, I request my child be taken to _____ hospital. If the school or hospital is unable to contact me, I hereby authorize the school and/or physician to treat my child as they deem necessary.

Physical Exam Date _____
 Insurance Information: Company Name _____ Policy Number _____

Signature of Parent or Guardian *Date*

OFFICE USE: EMERGENCY CARD TO BE RETAINED BY SPONSOR/COACH AND TAKEN ON TRIP