Use Pen and Press Firmly

ROXBURY DISTRICT ATHLETIC EMERGENCY INFORMATION

Name____ Male ____ Female ___ DOB__________
Address____
Athlete lives with (circle): both parents mother father guardian
Sport____
Grade______________________

Mother's Name________________________________Home Phone________________________
Cell______________________________________Work_______________________________

Father's Name________________________________Home Phone________________________
Cell______________________________________Work_______________________________

Emergency Contacts:
Name____Home Phone________________________
Cell______________________________________Work_______________________________
Name____Home Phone________________________
Cell______________________________________Work_______________________________

Family Doctor _____________________________________ Phone______________________
Dentist____ Phone______________________
Medical Insurance ______________________________ Policy #________________________

I give permission for my child's participation in the indicated sport for the 20____ season and to accompany the team on scheduled athletic trips. All athletes are covered by school insurance, which is an excess policy that can be used only after the family health insurance has been used. Please note that the rules of the New Jersey Board of Education require that the school district advise you, as a parent/guardian, of the possibility of physical hazards to your child.

I give permission to share medical information as needed with the appropriate personnel. I give consent for coaches, trainers and the team physician to use their own judgments in the application of first aid treatment and in securing medical aid and ambulance service as necessary.

Your signature is acknowledgement of notification and approval to participate.

_____________________________ ______________________________ ______________
Parent/Guardian Signature Student Signature Date

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(OFFICE USE ONLY)

PE Date_____________
Asthma_________ Medication/Inhaler________________
Allergies: Life Threatening ____________________________ Benadryl_____ EpiPen _____
Medication_______________________________
Medications currently taking ____
Chronic/Ongoing Medical Conditions____
Cardiac Conditions____
Protective Equipment needed____
Neurological Conditions/Concussion____
Other____
Glasses__________ Contacts______________

AD Signature__________________________ RN Signature ______________________________
Date________________ Date____________________