CROOK COUNTY HIGH SCHOOL
ATHLETIC EMERGENCY MEDICAL CARD

This form needs to be filled out and turned in to the athletic secretary every sports season

Last Name _____ First Name _____

Birth Date _____ Age _____ Home Phone _____

Cell Phone _____ Parent/Guardian Name _____

Address _____

Parent/Guardian Phone _____
Home Cell Work

Employer _____ Employer Address _____

Other Emergency Contact Name _____ Phone _____

Doctor _____ Doctor Phone _____

Allergies _____

Medical Alerts _____

Injuries In Past Two Years _____

Health Insurance Coverage _____

Health Insurance Number _____

In case of illness, accident, or emergency medical treatment, I hereby authorize the advisor or coach of my child to obtain emergency medical treatment. I agree that I am responsible for paying for said treatment. I release the Crook County School District from any liability of any kind associated with the actions taken in good faith by school district personnel in providing emergency medical treatment. I further agree that school district personnel may seek the nearest available treatment from any physician or medical facility.

By signing this form I agree that all information provided is correct and my child is covered by the medical insurance stated on this form. I have read this form and understand and agree with the content.

_____ _____
Parent/Guardian Signature Date