



NORTH WARREN REGIONAL ATHLETICS EMERGENCY MEDICAL CARD

PARENT'S AND/OR GUARDIANS:

All information must be completed before the student can participate in the NWR Athletic Program.

Student Name: _____ Date of Birth: _____

Parent or Guardian Name: _____ Emergency Phone: _____

Address: _____ Home Phone: _____ Business Phone: _____

Doctor: _____ Doctor's Phone: _____ Preferred Hospital: _____

Allergies: _____ Medications: _____ Medical Conditions: _____

ALTERNATE PERSON TO BE NOTIFIED

Name: _____ Relationship: _____ Phone: _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I give permission for emergency treatment for injuries sustained in any athletic event at the place of injury and at the discretion of the trainer or attending physician. In the event that I am unable to be reached and my child requires emergency medical treatment during any athletic event, I hereby authorize North Warren Regional School District and its' faculty members as my agent to act in my child's best interest in obtaining necessary transportation and medical care until I can be contacted. I hereby release North Warren Regional School District and its' faculty members from any claim arising out of the doctor's actions, and I agree to pay for any professional medical services incurred if my child is not covered by school insurance.

Signature of Parent/Guardian