

SPORT: _____

Olympia School District
Athletic Medical Card 2014-2015

LAST NAME FIRST NAME BIRTHDATE GRADE

PARENT/LEGAL GUARDIAN'S NAME (Please Print)

HOME ADDRESS STREET CITY ZIP

HOME PHONE WORK PHONE ALT PHONE Email Address

ALTERNATE PERSON(S) TO BE NOTIFIED IN CASE OF EMERGENCY:

NAME HOME PHONE ALT PHONE Email Address

PHYSICIAN OF CHOICE PHONE NUMBER

PREFERRED HOSPITAL PHONE NUMBER

NAME OF INSURANCE COMPANY ID NUMBER

If the parent/legal guardian and authorized physician named above cannot be reached at the time of emergency, and if immediate observation or treatment is urgent in the judgment of the school authorities, do you authorize and direct the school authorities to send the above named student (properly accompanied) to the hospital or doctor most easily accessible? YES NO

Do you agree to be financially responsible for all expenses incurred for treatment under the circumstances described above? YES NO

If the answers to any of the above questions are NO, please explain what action you desire school authorities to take.

List all allergies or other medical conditions the above named student has which first-aid/emergency personnel should be aware of (including head injuries and/or concussions).

PARENT/LEGAL GUARDIAN'S SIGNATURE DATE

Received By: Date Revised 4.30.12