EMERGENCY TREATMENT FORM FOR YOUR CHILD

THIS FORM MUST BE RETURNED TO THE HEAD COACH PRIOR TO THE FIRST PRACTICE.

Childs Name:_____

Address: _____ Zip Code _____

Telephone (home):_____ Date of Birth:_____

Father's Full Name _____ Mother's Full Name _____

Father's Address _____ Mother's Address _____

Allergies (bees, medications, food, etc.)_____

Medical Conditions (asthma, diabetes, heart murmur, etc.)_____

_____

Hospitalization History

WHY	WHEN	WHERE
_____	_____	_____

Medications the child is taking

Drug	Dose
_____	_____
_____	_____

Does child wear contact lenses? **[ ] Yes** **[ ] No**

Immunization History (Dates)

DPT _____ _____ _____ _____ _____ **Tetanus** _____ _____

Family Doctor_____ **Telephone**_____

Should a specialist's advice or services be required, preferences are:

Hospital _____ Telephone_____

Pediatrician_____ Telephone_____

General Surgeon _____ Telephone_____

Opthalmologist (Eye)_____ Telephone_____

Orthopedic Surgeon (Bone) _____ Telephone_____

Dentist _____ Telephone_____

Other_____ Telephone_____

If parents cannot be reached, please attempt to notify:

Name_____ Telephone_____

Name_____ Telephone_____

Other Remarks _____

I, the undersigned, have reviewed the above information and attest that it is true and accurate, In an emergency, if I am not available, the presentation of this form allows for the above named child to receive emergency treatment at the facility he/she presents to.

Signature of authorized person_____Relation_____Date_____