Emergency/Insurance Form

Please complete and return – PLEASE PRINT LEGIBLY

Athlete's Name: ______________________________ DOB: ___/___/__

Allergies: ____

Family Physician: ______________________________ Physician's Phone: ________________

Hospital Preference: ____

Note ANY special Medical Conditions: ____

Name of Emergency Contact: ____

Relationship to Student: ________________________ Contact Phone: ______________________

Family Insurance Company: ____

Address: ____ City/Zip: ____________________

Phone: ____

Insurance Policy #: ____________________________________ Group #: ____________________

Name of Employer Providing Insurance: ____

Parent's Name(s): ____

Address: ____ City/Zip: ____________________

Home Phone #: ___________________________________

Father's Work #: __________________________________ Cell #:___________________________

Mother's Work #: __________________________________ Cell #: ___________________________

Medical Consent

If, in the judgment of any representative of the Sonora ISD, the student named above should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given to the above student by any physician, athletic trainer, nurse, or school representative.

Parent Signature: ____________________________________ **Date**: ___/____/_____