

Eastview High School Emergency Information Card

Date _____ Grade _____

Name _____ Birth Date _____

Sport _____ Home Phone _____

Mother's Name _____ Work Phone _____

Father's Name _____ Work Phone _____

Non-Parent to notify in case of emergency _____

Phone No. _____

Family doctor _____ Phone _____

Hospital _____ Allergies _____

Eastview High School Emergency Information Card Athletic Trainer Authorization

This school employs a certified and registered athletic trainer through the Fairview Health Services Institute for Athletic Medicine for the purposes of educating student-athletes and preventing and treating injuries to the student-athletes while participating in school-related athletic events and programs.

I consent to the athletic trainer treating injuries and discussing any injuries or medical conditions with coaches, school staff and other qualified health care providers as deemed necessary within their scope of practice.

I understand that in the case of injury or illness requiring transportation to a health care facility, every attempt will be made to contact me but that, if necessary, the student-athlete will be transported via ambulance to the nearest hospital.

I acknowledge that I have received a copy of Fairview's Notice of Privacy Practices.

I have read this form and understand its contents at this date and time.

Parent/Guardian Signature _____ Date _____