

Print Students Name _____

2017 -18
Grade

**COLBY PUBLIC SCHOOLS – USD 315
ATHLETE EMERGENCY INFORMATION AND CONSENT FORM**

NAME _____

ADDRESS _____

ALLERGIES OR CHRONIC ILLNESSES _____

In case of accident, or illness or emergency, it is necessary for the school to know your preference for the care of your child. Please list three (3) choices.

PARENT / LEGAL GUARDIAN _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

PARENT / LEGAL GUARDIAN _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

RELATIVE, NEIGHBOR, OR FRIEND _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

INSURANCE COMPANY _____ ID# _____

If parent or guardian cannot be contacted, we, the undersigned parents/guardians of the child identified above hereby authorized officials of the above School District to contact directly the following physicians of our selection, and we hereby certify that we are the parents/guardians of the said minor child and do authorize the physicians named below to render such treatment as said physicians or either of them may deem reasonably necessary, in an emergency, for health of said child, without further authorization than here expressed. In the event neither of the physicians here named can be contacted or either of us is unavailable to give our express consent at such time with reference to any other physician, we hereby consent and authorize said physicians to render such treatment as he/she may deem reasonably necessary, in what he/she may consider to be an emergency, for the health of our aforesaid minor child.

(1st choice)
PHYSICIAN: _____ PHONE: _____

(2nd choice)
PHYSICIAN: _____ PHONE: _____

HOSPITAL
PREFERENCE: _____ PHONE: _____

DENTIST: _____ PHONE: _____

Expense incurred as a result of emergency ambulance use or treatment by physician will not be borne by the school or school personnel.

Signature of Parent or Legal Guardian

Date