Sport: _____ Season: Fall Winter Spring

JEFFERSON COUNTY SCHOOLS' ATHLETIC EMERGENCY CARD

Name of Athlete _____. This card is to be filled out by Parent or Guardian.
Please Print

NAME _____ / _____ / _____
Parent or Guardian Signature Date

ADDRESS _____ PHONE: Home _____ Business _____

E-MAIL _____ Cell _____

POLICY NUMBER _____ INSURANCE COMPANY _____

FAMILY DOCTOR (1) _____ PHONE _____

(2) _____ PHONE _____

RELATIVE (1) _____ PHONE: Home _____ Business _____
(or Authorized individual)
(2) _____ PHONE: Home _____ Business _____

In the event parent, family doctor, relative, or authorized individual cannot be reached, indicate your hospital preference:

(1) _____ (2) _____

IF CONTACT CANNOT BE MADE WITH ANY OF THE ABOVE, THE COACH WILL USE HIS/HER BEST JUDGMENT TO PROTECT AND ASSIST THE INJURED ATHLETE IN ACCORDANCE WITH THE FOLLOWING POLICIES: **A**. Caring for the athlete. **B**. Notifying the athlete's parents or guardian, or if these cannot be reached, for following the directions given on the athlete's emergency card. **C**. In extreme cases, getting the athlete under professional care with or without family permission. **D**. In cases of a need for emergency rescue aid a coach should call 911. **E**. Complete an accident report.
FOR EMERGENCY RESCUE AID – CALL 9-1-1

Jefferson County schools do not provide any accident or health insurance coverage for students while participating in interscholastic athletics. It is the parent/guardian's responsibility to provide insurance coverage for his/her child.

Other helpful information _____

Form 46-003500 Rev. 1-10

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR STUDENT ATHLETES

Athlete Name: _____ Age: _____

School Name: _____

Consent for Athletic Conditioning, Training, and Health Care Procedures

I hereby give consent for my child to participate in the school's athletic conditioning and training program and to receive any necessary health care treatment, including first aid, diagnostic procedures and medical treatment, which may be provided by treating physicians, nurses and other healthcare providers, including Certified Athletic Trainers. The Certified Athletic Trainers have my permission to release athletic injury information about my child to the school. In the event I cannot be reached in an emergency, I hereby give permission for my child to be transported to receive necessary treatment. I understand that the Certified Athletic Trainers do research in the prevention of athletic injuries and use generalized information that does not personally identify the individual student. The Certified Athletic Trainers may use this generalized information that does not identify my child in such research.

Parent or Guardian Signature _____ Date _____

This card is valid from August 1, 20___ - July 31, 20___.
Note: If any changes in the above information occur, a new card must be completed by the parent or guardian as soon as possible.
Revised 04-05