# EMERGENCY/MEDICAL FORM - D.H.S GIRLS SOCCER

**For the _____/_____ School Year** **Date of Birth:_____**

**Students Name:_____** **Home Phone:_____**
LAST FIRST

**Address:_____** **Town:_____** **Zip:_____**

**Parent(s) or Guardian(s) Name(s):_____**

**Player's Cell: _____** **Mom's Cell:_____** **Dad's Cell:_____**

**Mom's Work Phone:_____** **Work Location/Hours:_____**

**Dad's Work Phone:_____** **Work Location/Hours:_____**

**If unable to contact either parent (or Guardian) whom do you desire we contact?**

**Name:_____** **Relationship:_____** **Phone:_____**

**Name:_____** **Relationship:_____** **Phone:_____**

**Physician Name:_____** **Phone:_____**

**Physician Address:_____**

**Preferred Place of Medical Treatment:_____**

**Please list history of any previous injuries/operations:_____**

**Special Medical Conditions (including Asthma):_____**

**Allergies (Please give specific instructions for severe or dangerous allergic reactions - include food allergies)**

**MEDICAL INSURANCE Carrier (i.e. GHP, etc.):_____ Number :_____**

**Any Special Restrictions or Remarks:_____**

**My child may take the following when judged appropriate by school personnel for Minor Illness or Injury: TYLENOL___ IBUPROFEN___ NONE___**

**In case of accidental or serious illness, I request the school to contact me or my designate. If this cannot be done I authorize the School (Coaching staff) to call the physician listed above and follow his/her instructions. If the physician named above cannot be reached the school may seek medical services deemed necessary including emergency care. I realize the school district cannot assume responsibility for payment of medical expenses.**

**SIGNATURE OF PARENT (OR GUARDIAN):_____ Date:_____**