

DOUGLAS COUNTY SCHOOL DISTRICT RE-1
ATHLETIC REGISTRATION/EMERGENCY INFORMATION CARD
COACH'S COPY

Office use only: SPORT _____ PAID _____
--

SCHOOL: _____ GRADE: _____

NAME: _____ BIRTHDATE: _____ AGE: _____ SEX: _____

ADDRESS: _____ CITY/ZIP: _____

PARENT/GUARDIAN'S NAME: _____ HOME PHONE: _____

FATHER'S DAYTIME PHONE: _____ MOTHER'S DAYTIME PHONE: _____

IN AN EMERGENCY, IF PARENTS CANNOT BE REACHED, NOTIFY:

NAME: _____ PHONE: _____

FAMILY PHYSICIAN: _____ PHONE: _____

HOSPITAL (important to indicate): _____ PHONE: _____

FAMILY DENTIST: _____ PHONE: _____

List special health concerns: _____

I hereby give my consent for medical treatment deemed necessary by physicians designated by school authorities and/or for transportation to a hospital emergency room for treatment for any illness or injury resulting from his/her athletic participation. I understand this authorization will only be enforced when I cannot personally be contacted and provide for immediate treatment.

Signed (Parent or Guardian)

Date
