

Lincoln-Way East High School
 Permission to Participate
EMERGENCY INFORMATION FORM

Dear Parents/Guardians:

This form is for the athletic trainer/coach/sponsor to use in the event that we are unable to contact you in an emergency. This information will be kept by the athletic trainer/coach/sponsor and will be taken to all practices and extracurricular events. Information that is given will be kept in the strictest confidence. This form enables us to provide the best care possible for our students. If you have any questions, please feel free to call the athletic department or the activity director.

Student Name: _____ ID# _____ Age: _____ Gender: _____ Birth Date: _____

Address: _____ Town/Zip Code: _____

Home Phone: _____ Work/Cell Phone: _____

Person to contact in case of an emergency: _____ Phone #: _____

In the event that I cannot be contacted, I GIVE MY PERMISSION for the Lincoln-Way Central High School athletic training staff/coaching staff/club sponsor to seek medical treatment for my son/daughter in the case of injury/illness which is incurred while participating in school sponsored activities.

If my child is not presently covered by my family hospitalization and medical policy, I will need the student accident policy. I understand that if I check this statement I must purchase the accident policy from the school or my child will not be permitted to participate in athletics or extracurricular activities.

(CHECK ONE) I NEED ACCIDENT INSURANCE MY CHILD IS COVERED BY A FAMILY POLICY

Parent or Guardian Signature: _____ Date: _____

IMPORTANT MEDICAL INFORMATION

Sport(s) _____ Activity(s): _____

Previous serious injuries (fractures, concussions and surgical procedures): _____

Have you lost a paired organ? (kidney, etc.)	Yes _____	No _____
Are you epileptic?	Yes _____	No _____
Have you had any seizures?	Yes _____	No _____
Are you diabetic?	Yes _____	No _____
Are you allergic to bee stings?	Yes _____	No _____
Do you have asthma?	Yes _____	No _____
Have you ever had heat illness?	Yes _____	No _____
Do you wear glasses/contact lenses?	Yes _____	No _____
Are you allergic to any medications?	Yes _____	No _____

Family Physician: _____ Phone: _____

Do you take a daily/weekly medication? Yes _____ No _____

If yes, what medications are you taking? _____

Additional information important to student's health: _____