# ATHLETIC EMERGENCY CONTACT

## 2018-2019

Last Name: _____ First Name: _____ Student ID: _____

School Grade Year **2018-19**: 7 8 9 10 11 12

Birth Date: _____ Sex: F / M

Address:_____ City:_____Zip: _____

Home Phone:_____ Student Cell:_____

Mother's Name: _____Home Phone: _____

Work Phone:_____ Cell Phone: _____

Father's Name: _____ Home Phone:_____

Work Phone:_____ Cell Phone:_____

Emergency Contact Name: _____Relationship:_____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Allergies: ☐ YES ☐ NO List if yes_____

Medical Alerts: ☐ YES ☐ NO List if yes_____

Contact Lens\Glasses: YES \ No If Yes explain: _____

Family Physician: _____ Phone#: _____

Insurance Company:_____ Phone #:_____

Policy Holder:_____ Policy #:_____ ID #_____

Medication Permit: Licensed Athletic Trainers designated by the Aransas Pass Independent School District Board are hereby given my consent to administer non-prescription medication to said student after consultation with the team physician. Further consent is hereby given to administer prescription medication to said student when prescribed by the team physician and/or personal physician. **Parent initial: _____**

**Print** Parent/Guardian Name: _____

Parent/Guardian **Signature**: _____ Date:_____