West Essex Regional School District

Athletics Emergency Information Verification Form

Please Print

Student's Name_____Grade_____Sport_____

Student's Date of Birth_____ Sex_____

Student's Address_____

Guardian 1:_____Primary #_____

E-Mail_____Cell_____Work_____

Guardian 2:_____Primary #_____

E-Mail_____Cell_____Work_____

Emergency Contact 1:_____Primary #_____

Cell_____Work_____

Emergency Contact 2:_____Primary #_____

Cell_____Work_____

Medical Alerts/Allergies_____

Meds Taken Daily_____

Hospital Preference_____Pediatrician_____

_____ _____

Parent Signature Date