BMS-Sports

Bernardsville Middle School Sports

EMERGENCY MEDICAL INFORMATION

Name: _____ Age: _____ Date of Birth _____

Address: _____ Home Phone: _____

Father's Name: _____ Cell# _____ Home# _____

Employer _____ Work Phone# _____

Employer's Address: _____

Mother's Name: _____ Cell# _____ Home# _____

Employer _____ Work Phone# _____

Employer's Address: _____

If a parent cannot be reached, who should the coach contact to be responsible for this athlete?

Name: _____ Relationship: _____

Home # _____ Cell# _____

Family Physician: _____ Phone # _____

In case none of the above can be reached and an Emergency exists, may a doctor handle the case?

Yes _____ No _____

Allergies (include allergies to particular medicines and insects)

Physical disorders

If a student is currently taking medicine, please list: _____

Contact Lenses _____ Dental Appliances _____

Primary Insurance Company _____

Phone # _____ Policy Issued To: _____

Policy # _____ Group # _____ Expiration date _____

Reliable information is necessary should a sudden accident or illness occur while your son/daughter is participating in athletics. We will, of course, attempt to contact you if any type of medical attention is needed. However, in the event treatment is necessary and we are unable to contact you, your signature below will authorize the local medical authorities, physician, or hospital to use their best judgment in the interest of your child's health.

EMERGENCY TREATMENT PERMISSION

Authorization is hereby given to any doctor or hospital to perform any necessary emergency treatment of my child. Or for medical transportation as needed. His/her medical history is listed on this form.

Signature of Mother _____

Signature of Father _____