



CROOK COUNTY MIDDLE SCHOOL ATHLETIC EMERGENCY MEDICAL CARD

This form needs to be filled out and turned in to the coach for all athletes at CCMS

Athlete Name _____ Grade _____
School _____ Birthdate _____ Age _____
Home Phone _____ Cell Phone _____
Home Address _____
Mother/Guardian _____ Phone _____
Work Phone _____
Father/Guardian _____ Phone _____
Work Phone _____
Emergency Contact _____ Phone _____
Work Phone _____

Health Information

Any Known Allergies _____
Medical Alerts _____
Health Insurance Company _____

In case of illness, accident, or emergency necessitating medical treatment, I hereby authorize the advisor or coach of my child to obtain emergency medical treatment. I agree that I am responsible for paying for said treatment. I release Crook County School District from any liability of any kind associated with the actions taken in good faith by school district personnel in providing emergency medical treatment. I further agree that school district personnel may seek the nearest available treatment from any physician or medical facility as they deem best able to provide said treatment in the best interest of my child.

By signing this form I agree that all information provided is correct and my child is covered by the medical insurance stated on this form. I have read this form and understand and agree with the content.

Parent/Guardian

Date