

Emergency Medical Card

Student name: _____ Date of Birth: ____ / ____ / ____

Name of Parent/Guardian: _____

Cell Phone #: _____ Home/Work Phone #: _____

Name of Physician: _____ Phone: _____

Name of Insurance Company: _____ Policy #: _____

Preferred Medical Facility: _____

Allergies: Yes ____ No ____ Type: _____

List medications: _____

Athletics #4 (New 7-17)