

**First Aid and Emergency Medical Care
Grace Christian School – Sports**

STUDENT'S NAME: _____ **Grade:** _____ **Birthdate:** _____

Home Address: _____

Home Phone: _____ - _____ - _____

FATHER: _____

Cell Phone: _____

Employer: _____

Employer's Phone Number: _____ - _____ - _____

MOTHER: _____

Cell Phone: _____

Employer: _____

Employer's Phone Number: _____ - _____ - _____

Responsible Relative or Friend: _____

Telephone Number: _____ - _____ - _____

Cell Phone: _____

Family Doctor: _____

Address: _____

Telephone Number: _____ - _____ - _____

Family Dentist: _____

Address: _____

Telephone Number: _____ - _____ - _____

Local Hospital Preference: _____

Name of insurance company: _____

Policy Number: _____ Telephone Number: _____

The following are facts concerning my child(ren)'s medical history, including allergies, medications being taken, and any physical or emotional impairments to which medical personnel should be alerted. [Please include name of child and allergic reactions to any medication or drugs or other pertinent information needed for emergency treatment.] (Use additional sheet if necessary.)

If my child becomes ill or is injured, please proceed with first aid and emergency medical care. I also give my consent for any hospital or emergency treatment facility to provide emergency medical care. I understand the school officials will make every effort to contact me in case of such an emergency.

Parent or Guardian Signature

Date