

ATHLETIC MEDICAL & EMERGENCY INFORMATION

BETHANY LUTHERAN SCHOOL ♦ NAPERVILLE, IL

Athlete's Name _____ Phone (____) _____

Home Address _____
Street City Zip Code

Birth date _____ Age _____

Father _____ Work Phone (____) _____ Cell Phone (____) _____

Mother _____ Work Phone (____) _____ Cell Phone (____) _____

Name of responsible adult who will assume responsibility for your child if the parents cannot be reached:

Name _____ Phone (____) _____

Address _____
Street City Zip Code

Family Physician _____ Phone (____) _____

Address _____
Street City Zip Code

Insurance Company _____ Phone (____) _____

Policy No. _____

		Good	Fair	Poor	
1.	How is your child's health?				
2.	Does your child have any physical disability or limitations?	Yes		No	
3.	Is your child under a doctor's care?	Yes		No	
4.	Is your child taking any kind of medication?	Yes		No	
	Comment on type, dosage, frequency _____				
5.	Does your child have asthma?	Yes		No	
	Does your child carry an inhaler?	Yes		No	
6.	Has your child had a Tetanus Shot?	Yes		No	Date _____
7.	Has your child had any major illness in the past year?	Yes		No	
	Comments _____				
8.	Does your child have any allergies or any reactions to foods, plants, insects, or animals?	Yes		No	
	Comment on type of reaction and action to be take if reaction occurs _____				

IF YOU OR THE PHYSICIAN INDICATED ABOVE CANNOT BE REACHED IN AN EMERGENCY AND, IF IN THE JUDGEMENT OF THE SCHOOL AUTHORITIES, IMMEDIATE MEDICAL AND/OR HOSPITAL ATTENTION IS INDICATED, SO YOU AUTHORIZE RESPONSIBLE SCHOOL AUTHORITEIS TO SEND YOUR CHILD, PROPERLY ACCOMPANIED, TO AN AVAILABLE HOSPITAL OR PHYSICIAN? YES NO

Signature of Parent or Legal Guardian _____ Date _____

AS A PARENT AND/OR LEGAL GUARDIAN, I AUTHORIZE THE TREATMENT OF THE ABOVE NAMED MINOR, BY A QUALIFIED AND LICENSED MEDICAL DOCTOR, IN THE EVENT OF A MEDICAL EMERGENCY WHICH, IN THE OPINION OF THE ATTENDING PHYSICIAN, MAY ENDANGER HIS OR HER LIFE, CAUSE PHYSICAL DISABILITY OR UNDUE DISCOMFORT IF DELAYED. THIS CONSENT IS GRANTED ONLY AFTER A REASONABLE EFFORT HAS BEEN MADE TO REACH ME.

Signature of Parent or Legal Guardian _____ Date _____

Email _____ (REQUIRED)

THE RELEASE FORM IS SIGNED FREELY FOR THE SOLE INTENTION OF AUTHORIZING MEDICAL TREATMENT UNDER EMERGENCY CIRCUMSTANCES IN MY ABSENCE.