

CFBISD Athletic Emergency Form
R. L. Turner High School

BACKGROUND INFORMATION

Athlete's Full Name _____ Grade for School year _____ 9 10 11 12
Birth Date _____ Age _____ Student ID # _____ Sex: M F Sports _____
Home Address _____ Home Phone # _____
Father/Guardian's Name _____
Wk phone _____ Cell phone _____ Home phone _____
Mother/Guardian's Name _____
Wk phone _____ Cell phone _____ Home phone _____
If a preference: which parent/guardian should be called first? Father _____ Mother _____

EMERGENCY INFORMATION

Other persons to call in case of emergency if parents cannot be reached:
Name _____ Relation _____ Phone # _____
Name _____ Relation _____ Phone # _____
Family Physician _____ Family Physician Phone # _____
Does the athlete have asthma? Yes No If yes, carry an inhaler? Yes No
Does the athlete have diabetes? Yes No If yes: Injections/shots Pump Neither
List all items the athlete is allergic to: _____
List any other medical conditions: _____

INSURANCE INFORMATION

Person Insurance is Listed under _____ Group # _____
Insurance Company Name _____ Policy # _____
Insurance Co. Address _____ Phone # _____

MEDICAL CONSENT

(I) (We) the undersigned, parent(s)/legal guardian(s) of the named above, a minor, do hereby authorize the Carrollton-Farmers Branch Independent School District athletic staff as agent(s) for the undersigned to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general of special supervision of a licensed physician/surgeon, whether such diagnosis or treatment is rendered at the office of said physician/surgeon or at a hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital which has provided treatment to the above-named minor to surrender physical custody of such minor to (my) (our) above-named agent(s) upon the completion of treatment. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.
I hereby authorize the Athletic Trainer/coach and the physicians' caring for my child to communicate information regarding the health status of my child as it relates to their ability to participate or the care of their injuries / illness.

X _____ X _____
Parent /Legal Guardian Signature Date Parent /Legal Guardian Signature Date