Indian Community School
10405 W. St. Martins Road
Franklin, WI 53132

ATHLETIC EMERGENCY / HEALTH CARD

Name _____
(Last) (First) (Middle Initial)

Date of Birth _____ Age _____ Grade _____

Social Security # _____ Sex: Male Female

Student's Address _____ Tel. #_____

Mother's Name _____ Mother's Work Tel. #_____

Mother's Address _____ Tel. #_____

Father's Name _____ Father's Work Tel. #_____

Father's Address _____ Tel. #_____

People to contact if parents/guardians cannot be reached:

Name _____ Relationship _____ Tel. # _____

Name _____ Relationship _____ Tel. # _____

Medical Insurance Company _____ Policy or Group # _____

Allergies, Medical Conditions, Medications _____

_____

Contacts? Yes _____ No _____ Glasses? Yes _____ No _____

Family Dentist _____ Tel. # _____

PERMISSION TO TREAT

If emergency medical treatment is required, what facility do you prefer to be taken?

_____

We/I the parent(s) guardian(s) of _____ give permission for emergency medical treatment of this child in case of illness or accident and accept responsibility for medical expenses incurred on behalf of the child.

Date _____ Parent/Guardian _____

Date _____ Parent/Guardian _____

7/21/11