

**HEALTH EMERGENCY INFORMATION FORM  
FOR INTERSCHOLASTIC SPORTS**

Sport: \_\_\_\_\_

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Sex: M: \_\_\_\_\_ F: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Mother's Names: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Home/Cell Phone #: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Persons to Contact if Parents are Unavailable:**

Contact #1:  
Name: \_\_\_\_\_

Contact #2:  
Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Home/Cell Phone # \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Emergency Information:**

Family Physician and/or clinic facility: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

My son/daughter has the following medical problems, chronic disease or allergies: \_\_\_\_\_  
\_\_\_\_\_

Contact lenses worn? Yes \_\_\_\_\_ No \_\_\_\_\_

**Please specify any and all medications your son/daughter takes regularly or carries with him/her:**

1. Prescription inhaler for asthma? Yes \_\_\_\_\_ No \_\_\_\_\_  
Name of asthma medication: \_\_\_\_\_
2. Is this used before sports activities Yes \_\_\_\_\_ No \_\_\_\_\_
3. Epipen (Adrenaline) for diagnosed bee sting allergy? Yes \_\_\_\_\_ No \_\_\_\_\_

**IF YES, MUST CARRY WITH HIM/HER AT ALL TIMES.**

Any other medication(s)?: \_\_\_\_\_

Date: \_\_\_\_\_