



**Hillsborough High School Athletics
Emergency Information**

Name: _____ Age: _____ Grade: _____

Sport: _____ Home Phone: _____

Address: _____

Name- Parent/Guardian:

Mother: _____ Cell Phone: _____

Email Address: _____ Work Phone: _____

Father: _____ Cell Phone: _____

Email Address: _____ Work Phone: _____

IN AN EMERGENCY WHEN PARENTS/GUARDIAN CANNOT BE CONTACTED:

Notify: _____ Phone #: _____

Family Doctor: _____ Phone#: _____

Preferred Hospital: _____

The team physician, trainer, and coach may apply first aid treatment until medical aid and/or ambulance arrives:

_____ YES or- _____ NO

We give our consent for coaches, trainers and team physicians to use their own judgment in securing medical aid and ambulance service in the event of an emergency.

_____ YES -or- _____ NO

Date: _____ **Parent/Guardian Signature:** _____

Please check all that apply:

Asthma _____
Epilepsy _____
Diabetes _____
Kidney Failure _____
Heart Problem _____

Allergies:
Medication _____
Pollen _____
Bee Sting _____
Other (indicate) _____

If allergic to medication, please state medication: _____

Are you taking medication at the present time? _____ YES -or- _____ NO

If yes, state medication and reason for use: _____
