



# Hanover Central Athletics

## Athletic Information and Emergency Medical Treatment Waiver

To be filled out at the beginning of each sports season

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade \_\_\_\_\_

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

Mother's Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_

If you cannot be reached using the above information at time of serious injury or illness, school authorities have permission to contact either of the below individuals who will help assure responsibility until you can be located.

### Emergency Person -1

Full Name: \_\_\_\_\_ Relation to family: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

### Emergency Person -2

Full Name: \_\_\_\_\_ Relation to family: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

The athletic department is seeking your permission to have your son or daughter treated at a doctor's office or a hospital emergency room in the event that he or she is found in need of emergency medical treatment. If an emergency occurs every effort will be made to contact you. If such contact is not possible this sheet may facilitate prompt treatment.

I hereby give my permission for the above stated student to receive emergency medical treatment.

Date \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_

Insurance Co. Name & Policy No. \_\_\_\_\_

*Please list any additional medical conditions or injuries that you feel we should be aware of such as, allergies, asthma, diabetes, etc.*