

# New Trier High School Emergency Information

Name: \_\_\_\_\_ Year in School:  Fr  Soph  Jr  Sr

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_

Father's Name: \_\_\_\_\_ Father's Work Phone: (\_\_\_\_) \_\_\_\_\_

Father's Cell Phone: (\_\_\_\_) \_\_\_\_\_ Mothers Cell Phone: (\_\_\_\_) \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Mother's Work Phone: (\_\_\_\_) \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Number: (\_\_\_\_) \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Please indicate **ANY** medical conditions: allergic reactions, contact lenses (hard/soft), asthma, previous injuries, current medications (and why), etc.

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I give my consent/permission to any supervising coach of any sport in which my child is at or participating in for New Trier High School, and the right, on my behalf and in my stand, to arrange for licensed and certified physicians and/or athletic trainers to render and provide immediate treatment to my child as to injuries that may be sustained by my child while participating in such sport, whether directly or indirectly, and whether sustained during practice or in active interscholastic competition, and all without necessity of any further or additional express authorization by me other than for this authorization.

My above permission and consent also extends to the right of any such supervising coach or school personnel to arrange for immediate medical treatment by a licensed or certified physician and/or athletic trainer, and for them to apply such emergency techniques as may be necessary to my child where the same, in their judgment, is deemed appropriate by reason of any injury sustained by my child, and where the same, in their judgment, is deemed reasonably necessary to preserve life or limb of my child.

Signature: \_\_\_\_\_

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

