FORT EDWARD PUBLIC SCHOOL ATHLETE EMERGENCY CARD _____

DATE

Name _____ Age ____ Date of Birth _____
Last First

Address _____ Home Phone _____

Parent/Guardian _____ Business Phone _____

Family Physician _____ Phone _____

In the event of a medical emergency, I give my permission for _____
Name
to receive emergency medical transportation and treatment at the nearest medical facility.

MEDICAL COVERAGE
INS. I.D. # _____

_____
Signature - Parent or Guardian

Please indicate any medicine or treatment which SHOULD NOT be used.

_____