

CENTRAL LUTHERAN SCHOOL
SPORTS EMERGENCY INFORMATION

STUDENT'S NAME: _____

PARENTS NAMES: _____

ADDRESS: _____

PHONE: _____

MOM'S CELL: _____

DAD'S CELL: _____

EMERGENCY CONTACTS:		PHONE
NAME	RELATIONSHIP	HOME/WORK
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

In case of accident or serious illness, I request the school to contact us. If the school is unable to reach us, I hereby authorize the school to call the physician indicated below and to follow his instructions. If it is impossible to contact this physician, the school may make whatever arrangements are necessary.

DATE: _____

Signature of Parent or Guardian

Physician: _____ Dentist: _____

Address: _____ Dentist Phone: _____

Physician Phone: _____ Hospital Preference: _____

PARENTS: PLEASE FILL IN THE FOLLOWING INFORMATION:

- Does your child have any allergies? Yes ___ No ___
If yes, to what? _____
- Does your child take any medication on a regular basis? Yes ___ No ___
If yes, to what? _____
- Does your child have glasses or contacts? Yes ___ No ___
- Has your child had a communicable disease within the past year? Yes ___ No ___
If yes, to what? _____
- When was your child's last dental exam? _____
Please list any dental problems: _____
- Has your child had surgery, serious illness or injury during the past school year? Yes ___ No ___
- Does your child have a history of ear infections, tubes in ears, or hearing difficulties?
Please explain: _____
- Does your child have a chronic illness such as seizures, diabetes, asthma, anemia, bleeding, hypertension, heart condition, episodes of upper respiratory infection, or strep throat, bladder or kidney problems, etc.? If yes, what? _____
- Are there any other health problems the school may need to be aware of? Please list. _____