Floyd Central High School
Student/Athlete Emergency Information
Athletic Department

Student/Athlete:______________________________________ Birth date:_____________ Grade:_________

Address:____ Phone:__________________

Parents Work Phone Numbers: Father__________________________ Mother__________________________

IN CASE OF EMERGENCY, (IF PARENT CANNOT BE CONTACTED):

NOTIFY:__________________________________ **PHONE NUMBER:**______________________________

Family Doctor Information
Doctor Name:____ Phone:___________________________

Date of Last Tetanus Shot:___________ Allergies:____

Current Medications:____

Preferred Hospital ____

I authorize for coaches, athletic trainers or team physician to use their own judgment in:

Securing medical aid:	YES	NO	*(please circle one)*
Ambulance Service:	YES	NO	*(please circle one)*

PARENTAL AUTHORIZATION
CONSENT TO MEDICAL TREATMENT FOR CHILD

I,____, of ____,
(Name) *(Address)*
am the parent having legal custody of the child listed above. While being absent from my child, from
________________ until ________________ I have entrusted his/her care to:
mo. day year mo. day year

Name: Floyd Central High School – Athletic Coaching Staff

Address: 6575 Old Vincennes Road, Floyds Knobs, IN 47122

I authorize the adult(s) listed above to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care, to be rendered to the child under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the Commonwealth of Kentucky and/or state of Indiana.

Medical Insurance Information: Policy Holder____

Insurance Company____

Policy Number__________________________ Group Number________________

This authorization shall only be effective during my absence on the dates set forth above. I agree to be financially responsible for all costs of medical treatment rendered to my child.

Signed:____ Date:_____________________________
Parent/Guardian

NOTE: COMPLETE BOTH SIDES