Cherry Valley-Springfield Central School
Athletic Emergency Information

Athlete's Name:_____

Home Address:_____

_____

Home Phone:_____

Date of Birth:____/____/____ Age:_____ Grade:_____ Year Entered 9th Grade:_____

Parent/Guardian Name:_____
Relationship_____
Home phone #:_____
Cell phone #:_____
Work phone #:_____

Parent/Guardian Name:_____
Relationship_____
Home phone#:_____
Cell phone #:_____
Work phone #:_____

Name of another responsible individual to be notified if parents cannot be reached:_____
Relationship_____
Phone #:_____

Preferred Hospital:_____
Phone #:_____

Prime Care Provider Name:_____

Athlete's Latest Tetanus:_____
Medical information the coach needs to know about your son/daughter:
_____

In the event of an emergency requiring medical attention, I hereby grant permission to a physician or other hospital personnel designated by the Cherry Valley-Springfield School District Coaching Staff to attend to my son/daughter. I expect every effort will be made to contact me in order to receive my specific authorization before any treatment or hospitalization is undertaken.

Parent/Guardian Signature:_____ Date:_____