GREAT VALLEY HIGH SCHOOL – EMERGENCY ATHLETIC CARD

Student Information: Student's Name (Last, First)_____ Birth date:_____ Grade: _____
Fall Sport:_____ Winter Sport: _____ Spring Sport: _____
Address:_____
Guardian #1:_____ Guardian #2:_____
Relationship:_____ Student resides with: YES NO (circle one) Relationship:_____ Student resides with: YES NO (circle one)
Home Phone #:_____ Work Phone #:_____ Home Phone #:_____ Work Phone #:_____
Cell Phone #_____ Other Phone#:_____ Cell Phone #_____ Other Phone#:_____
Email:_____ Email:_____

Emergency Contact Information (List two people who will assume temporary care of your student if necessary)
Contact #1:_____ Relationship:_____ Phone #1: _____ Phone #2: _____
Contact #2:_____ Relationship:_____ Phone #1: _____ Phone #2: _____

Medical Information: Family Doctor:_____ Phone #:_____ Dentist:_____ Phone #:_____
Current Health Problems:_____
Current Medications:_____
Asthma: YES NO (circle one) Treatment:_____
Diabetes: YES NO (circle one) ___Yes ___No: Treatment:_____
Allergies: YES NO (circle one) ___Yes ___No: Treatment:_____
Known Bee Sting Allergy: YES NO (circle one) Is EPIPEN required: YES NO (circle one) Treatment:_____

HIPPA Statement: I/we understand the information on this card may be shared with appropriate personnel including the Athletic Training Staff, the School Nurse, the Athletic Department and the Coach of the respective sport.

Acknowledgement of Risk and Consent to Participate: I/We hereby acknowledge an awareness that participation in sports involves a risk of injury, which may include severe injuries possibly involving paralysis, permanent mental disability, or death, and that these injuries may occur in some instances as the result of unavoidable accidents. I/We accept these risks in giving consent to participate in sports by the undersigned athlete.

Authorization for Emergency Treatment of Minor:

- The undersigned is the parent/legal guardian of the minor identified Hospital for us in the event of the need for emergency treatment of the minor identified on this card when neither the undersigned, the family physician nor the relative or friend identified on this card can be reached to provide consent to treatment.
- Great Valley School District carries insurance on all school athletes.
- The undersigned hereby authorizes the Chief Physician of Emergency Services for *Paoli Memorial Hospital/Phoenixville Hospital or his designee (who must be a fully licensed Physician) to perform such emergency treatment or procedures as he or she deems appropriate, provided, however that my consent or the consent of the family physician, friend or relative identified above will first be sought unless the delay in communicating with such persons is, in the opinion of the physician, imprudent under the circumstances. *Local hospital in the event of an away contest.

I/We have read, understand and agree to the above listed statements (HIPPA, Acknowledgement of Risk and Consent to Participate, Authorization for Emergency Treatment of Minor).

_____ _____
Signature of Parent/Guardian Date Signature of Student Date