2019-2020 CAPA MARQUEE AWARDS
Emergency Medical Form

(Please print.)

Name of Student Participant: ____

DOB: ______________________________ Age: _______ Gender: ______________

High School: ____

TO NOTIFY IN THE EVENT OF AN EMERGENCY:

Parent/Guardian Name: ______________________________ Cell: _______________

Parent/Guardian Name: ______________________________ Cell: _______________

NAME OF RELATIVE (in case neither of the above can be reached):

Name: ____ Cell: __________________

Relationship: ____

PHYSICIAN: _______________________________________ Phone: ______________

DENTIST: ____ Phone: ______________

PREFERRED HOSPITAL: ____

INSURANCE COMPANY: ____

POLICY NUMBER ____

ALLERGIES: ____

MEDICAL CONDITIONS: ____

____

By signing below, I consent to the administration of first aid and/or the dispatching of 911 emergency services in the event of a medical emergency.

SIGNATURE OF PARTICIPANT: ______________________________ Date: __________

SIGNATURE OF GUARDIAN: _________________________________ Date: __________