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: _____