EMERGENCY CONTACT/ INSURANCE INFORMATION

Student Name: _____

Name of sports you plan to participate in:

Fall_____Winter_____Spring_____

Should a medical emergency occur we will make every effort to contact you about treatment for your son or daughter. In the event you cannot be reached, we ask that you give us permission to provide emergency medical treatment and any follow-up care by a licensed physician.

I, THE UNDERSIGNED OR DESIGNATED REPRESENTATIVE FOR THE STUDENT, GIVE MY CONSENT FOR CARE. I GRANT PERMISSON TO ARIZONA CHARTER ACADEMY TO PROVIDE EMERGENCY TREATMENT FOR _____ (SON OR DAUGHTER) AND FOLLOW UP CARE BY A LICENSED PHYSICIAN. I UNDERSTAND THAT NO GUARANTEES OR PROMISES ARE MADE CONCERNING THE OUTCOME OF TREATMENT.

_____ _____ _____

Signature of Parent/Guardian Today's Date Student's Date of Birth

Parent/ Guardian Name:_____
Home Phone:_____
Address: _____
City: _____ Zip: _____
Father's Business Phone: _____Mother's Business Phone:_____
Father's Cell Phone: _____Mother's Cell Phone: _____

IN CASE OF EMERGENCY: If parent/guardian is not immediately available, contact:

Friend/Relative: _____Phone:_____

Family Physician:_____Phone: _____

Hospital Preference:

_____

MEDICAL ALERT(S)

_____

Insurance

I clearly understand that it is the school district's policy that all students participating in interscholastic activities must have insurance and that the school cannot pay any medical cost from injury to a student.

Insurance Company: _____Policy Number: _____

Please provide copy of insurance card, both front and back.