

Last Name: \_\_\_\_\_  
Sport(s): \_\_\_\_\_  
School Year: 200\_\_-200\_\_

**WEATHERFORD INDEPENDENT SCHOOL DISTRICT  
ATHLETIC MEDICAL EMERGENCY CARD**

Full Legal Name: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ (Last) (First) (Middle)  
Grade: \_\_\_\_\_ Gender: **M** **F** Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_  
Social Security Number: (For school Insurance Purpose) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Home Address: \_\_\_\_\_ Zip Code \_\_\_\_\_

**Primary Parent / Guardian Information**

**FATHER:** \_\_\_\_\_ **MOTHER:** \_\_\_\_\_  
Is your address same as athlete? **Y** **N** Is your address same as athlete? **Y** **N**  
Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Work Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Cell / Pager: ( ) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell / Pager: ( ) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

In case of emergency, attempt to contact a parent at a number listed above. If we cannot be reached, attempt to contact an alternate listed below.

**Secondary Contact Information**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Work Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Cell / Pager: ( ) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell / Pager: ( ) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Primary Health Insurance Information**

Is your insurance plan **Personal or Employer?** (Please Circle one)  
Is the plan a managed care network? **Y** **N** If yes, type of plan: HMO - PPO - PCP  
Name of Person Insuring Athlete: \_\_\_\_\_  
Insurance Company/Provider Name: \_\_\_\_\_  
Plan #: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Employee ID # \_\_\_\_\_ Employer/Co. Name: \_\_\_\_\_  
Insurance Company Address: \_\_\_\_\_  
(City, State, Zip)

**Athletes' Primary Care Physician Information**

Dr: \_\_\_\_\_ Ofc. Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_  
Please list any medications your son or daughter is now taking on a regular basis: \_\_\_\_\_  
Please list any impaired organs your son or daughter might have: \_\_\_\_\_  
Please list any allergies that the medical staff should be aware of. Medications to be taken. \_\_\_\_\_

**Medical Treatment Waiver**

Permission is hereby granted to the attending physician to proceed with any medical treatment, X-ray examination, and intravenous injections for the above named student. If, in the judgement of any representative of the school, the above named student should need immediate care and treatment as a result of any injury or illness, I do hereby request, authorize, and consent to any such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

Student Signature: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_  
Date: \_\_\_\_\_ Date: \_\_\_\_\_